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TITLE PAGE

The bereaved therapist speaks: An exploration of humanistic therapists' experiences of significant personal bereavement and its impact on their therapeutic practice. A qualitative study using Interpretative Phenomenological Analysis.

Jeanne Roberta Broadbent

"Dissertation submitted to the University of Chester for the Degree of Master of Arts (Counselling Studies) in part fulfilment of the Modular Programme in Counselling Studies".

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ABSTRACT

The death of a loved one is an event that can shatter the carefully constructed edifice of one's everyday life and which can cause us to question our basic assumptions about ourselves and the world we inhabit. The purpose of this study was to explore the lived experiences of four humanistic therapists who had suffered a significant bereavement, and how this had affected their therapeutic practice. I chose a qualitative approach to the research underpinned by the epistemological and philosophical paradigms of phenomenology. The method chosen for analysing the data was Interpretative Phenomenological Analysis (Smith, Flowers & Larkin 2009). Data were collected by using semi-structured interviews which were subsequently transcribed and analysed using an inductive, iterative approach that starts with the particular and builds up themes. Four master themes emerged from the data analysis comprising eight sub-themes. The findings suggest that bereavement is a unique experience that can be influenced by a variety of factors, and which can challenge one's sense of self and social identity. It can also result in personal growth and renewal as the bereaved relearn the world and reconstruct their identity. A major finding was the theme relating to the interface between the personal and professional and how continued professional development, including supervision, informed the participants' practice. Finally, the findings suggest that through the process of working through their own grief, the participants' personal experience resulted in enhanced empathic understanding and connectedness in their therapeutic relationships. The findings are generally consistent with other research in this area, although there are also significant differences. Further research in this area could involve a longitudinal study on the relationship between the changing impact on practice and the evolving process of grieving.

DECLARATION

“The work is original and has not been submitted previously in support of any qualification or course”.

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LIST OF ABBREVIATIONS

BACP British Association for Counselling and Psychotherapy

CB Continuing Bonds

IPA Interpretative Phenomenological Analysis

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CHAPTER ONE: INTRODUCTION

And then one or other dies. And we think of this as love cut short; like a dance stopped in mid career or a flower with its head unluckily truncated and therefore lacking its due shape ... C.S. Lewis A Grief Observed

The death of someone we love can rip a jagged hole in the fabric of our lives such that it destabilises the axis of our assumptive world (Janoff-Bulman 1992; Kauffman 2002; Landsman 2002; Parkes 1998, 2000, 2009; Parkes & Prigerson 2010) and can cause us to question our place within it. As C.S. Lewis observes, the 'due shape' of our lives is forever altered following a bereavement and we must 'relearn the world' (Attig 2001, 2004, 2011) as it now presents itself before us in an endeavour to make sense of the loss and the changes it has wrought in our sense of self, identity and existential understanding (Doka 2002; Gillies & Neimeyer 2006; Holland, Currier & Neimeyer 2006; Matthews & Marwit 2006; Neimeyer 2000, 2001). Bereavement also presents us with a paradox in that whilst it is a universal phenomenon, experienced by all of us at some point in our lives, there exists a variety of circumstantial, environmental, socio-cultural and relational factors that can impinge upon the bereaved, thus making it a unique experience for each individual (Parkes 2000; Shuchter & Zisook 1993; Worden 2010). There is however, a growing body of evidence to suggest that the experience of loss, whilst deeply painful and traumatic, can also be transformative and life-enhancing (Bonnano 2004; Calhoun & Tedeschi 2001; Davis 2001; Neimeyer, Prigerson & Davies 2002; Schaefer & Moos 2001).

The background to this research study arose out of a synthesis of my personal experience of bereavement and my professional practice as a bereavement counsellor in a hospice. This synthesis of personal and professional experience in some ways mirrors the findings of a significant body of research that seeks to identify

salient factors in counsellors' and psychotherapists' personal and professional development over the course of their careers (Guy, 1981; Orlinsky & Rønnestad 2005; Rønnestad & Skovholt 2001, 2003; Skovholt & Rønnestad 1995). Embedded within this empirical research are thematic strands that relate to the influence of major life events such as personal illness, divorce and bereavement on therapists' professional practice. As I familiarised myself with this research I was aware that particular aspects of it resonated strongly with my own personal experience of bereavement and how this experience impacts upon and informs my professional work with clients. As a person-centred counsellor I am cognisant of the importance given to the counsellor's 'way of being' (Rogers 1980) within the context of the therapeutic relationship, and of the centrality of the 'core conditions' of empathy, unconditional positive regard (UPR) and congruence in effecting therapeutic change and growth in clients (Rogers 1957). Certainly, the notion of bringing the "essential elements" (Rogers in Baldwin 2000, p.30) of oneself into the relationship and of being 'real' and 'authentic' (ibid p. 36) is particularly intriguing not least because, in terms of the experience of bereavement, the 'self' (of the therapist) might undergo significant intrapsychic changes and reformulations. As Guy (1981, p.180) notes, bereavement can have a "significant impact on the personal life and professional work of the therapist".

Whilst there is a substantial body of literature on thanatology and on clients' experiences of bereavement and grief, there is very little specifically related to therapist bereavement, an observation made not only by a number of researchers (Bozenski 2006; Dunphy & Schniering 2009; Hayes, Yeh & Eisenberg 2007; Kouriatis & Brown 2011; Millon 1998; Wall 2001), but also by bereaved therapists themselves (Vamos 1993) in that there was "no body of clinical knowledge" (Givelber & Simon 1981, p.143) to support bereaved therapists. Thus there would appear to

be a serious omission in the literature particularly in terms of studies into 'therapist variables' within the context of research into therapeutic outcomes and the significant role of the therapeutic relationship in effective psychotherapy (Beutler, Machado, & Neufeldt 1994; Cooper 2008). The accounts that do exist are primarily (although not exclusively) anecdotal and reflective in form, written by therapists most of whom are psychoanalytical or psychodynamic in orientation (Chasen 1996; Felberbaum 2010; Gerson 1996; Lambert 2003; Mendelsohn 1996; Morrison 1996; Rappaport 2000; Ryan 2007; Shapiro 1985; Vamos 1993; Warshaw 1996; Weingarten 2010).

The first empirical qualitative study in this field was carried out by Millon (1998) in which she researched the bereavement experiences of ten psychodynamic psychotherapists and how their experiences impacted upon their clinical work. Subsequently, Bozenski (2006) undertook a collaborative qualitative research study in which she researched the impact of therapists' bereavement on their use of empathy. Other relevant studies written from a more theoretical perspective include those by Givelber & Simon 1981; Callahan & Dittloff 2007; Hayes, Yeh & Eisenberg 2009; Dunphy & Schniering 2009; Tsai, Plummer, Kanter, Newring & Kohlenberg 2010.

There are however, notable deficiencies in the existing literature. Firstly, therapists from a humanistic orientation are seriously under-represented in the literature reviewed in this study. Secondly, the majority of the accounts by the psychoanalytic therapists focus specifically upon dilemmas relating to personal self-disclosure of the death, and the consequent impact this might have on their ability to maintain neutrality and preserve the transference elements of the therapeutic frame. Thirdly, there is a singular lack of representative perspectives from therapists living and working in the United Kingdom.

The aim and purpose of this study therefore was to explore the phenomenological and 'lived experiences' (Reid, Flowers & Larkin 2005; Smith, Flowers & Larkin 2009) of four humanistic therapists who have experienced significant personal bereavement, in order to discover how and in what ways this experience impacts on their therapeutic practice with clients. This is a qualitative study underpinned by a phenomenological epistemology and philosophy which has as its primary concern the 'life world' (Dahlberg, Dahlberg & Nystrom 2008) of the participants. The study is placed within the wider context of thanatological research, and to the extant literature on therapist bereavement and its impact on practice. Reference is also made where appropriate to relevant discourses pertaining to counselling and psychotherapy. The study addresses the following specific research topic:

The bereaved therapist speaks. An exploration of humanistic therapists' experiences of significant personal bereavement and its impact on their therapeutic practice. A qualitative study using Interpretative Phenomenological Analysis.

The two main foci within the study include (i) an open-ended exploration of the therapist-participants' lived experiences of bereavement and its impact upon their coping strategies, world view, beliefs and sense of identity; and (ii) the impact of this experience on their professional practice including the therapeutic relationship with clients, the use of self-disclosure and supervision.

There is a clear rationale for this study in that due to the scarcity of literature on therapist bereavement, the study makes a significant contribution to the existing literature and further serves to increase understanding and discussion within the wider arena of counselling and psychotherapy research and practice. Moreover, the specific focus on humanistic therapists as participants in the study ensures that

practitioners from this orientation are given a voice (Romanoff 2001) and that their stories are 'witnessed'. The anecdotal and other evidence suggests that personal experience of bereavement can have both positive and negative effects on therapeutic work and therefore, through a detailed analysis of the data to produce a "rich description" (Marshall & Rossman 2011, p.72) of the phenomenon, this study adds to current understanding of how these effects are manifested. Moreover, the study links research and practice in thanatology, particularly in terms of its qualitative perspective (Carverhill 2002; Jordan 2000; Neimeyer 2004; Neimeyer & Hogan 2001; Silverman 2000) and contributes further to the research on the dyadic/dialogic nature of the therapeutic relationship (Baldwin 2000; Cooper 2008; McLeod 2003b; Mearns & Cooper 2005; Mearns & Thorne 2007). Another important factor in terms of the study's significance is the role of supervision. Grief is a long-term process and supervisors need to recognise this and provide opportunities for therapists to discuss their feelings and the possible impact on client work (Henderson 2005; Tudor & Worall 2007; Wheeler 2007). In this regard, the study may provide a source of interest and support for both supervisors and therapists facing similar difficulties. Finally, there may be implications for training and personal development.

The study is a qualitative study that explores the bereavement experiences of four practising humanistic therapists. The research is underpinned by a phenomenological-hermeneutic philosophy and methodology (Heidegger 1962) and the data resulting from semi-structured and transcribed interviews are analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin 2009; Willig 2008). The dissertation is structured as follows: Chapter Two comprises a review of the literature; Chapter Three presents a detailed overview of the methodology; Chapter Four comprises the findings arising from the data analysis; Chapter Five

offers a discussion of the data in relation to extant theory; and Chapter Six concludes the study and makes suggestions for further research.

CHAPTER TWO: LITERATURE REVIEW

There will be two domains of literature discussed below:

- (i) An historical overview of developments in the field of thanatology.
- (ii) An overview of the literature on therapists' experience of personal bereavement and its impact on their therapeutic practice.

(i). *Developments in Western perspectives on thanatology since Freud (1915[1917])* (Appendix 6: Table 5, p.85)

There is a substantial body of research in thanatology that is rich, dignified and thought-provoking in its consideration of difference and debate. As this review offers an historical perspective it has been necessary to access the seminal texts in this area in order to gain a perspective on the developments in thanatology up to the present day. These have included Freud's (1915[1917]) *Mourning and Melancholia*, Lindemann's seminal paper of 1944, the work of Kubler-Ross (1969/2009), Bowlby (1980), and research by Parkes (1972/1998) and Rando (1993). For more recent sources the journals *Death Studies*, *Omega* and *Mortality* have proved to be rich seams of information together with the edited works of Neimeyer (2001) and Stroebe, Stroebe & Hansson (2001).

Firstly, it is important to state that grieving is essentially a normal process that everyone at some time in their lives will experience (Shuchter & Zisook 1993). This process however can be deeply painful and distressing, affecting a person's emotional, cognitive, psychological and physiological equilibrium. Furthermore, as noted in Chapter One, significant loss challenges our "narrative coherence" (Neimeyer 2001, p.263) as well as our most basic assumptions about ourselves and the world (Janoff-Bulman 1992) impelling us to find a "new existential grounding for

[our] self-concept and life direction” (Neimeyer 2000, p.552). For some people the circumstances surrounding the grief, the nature of the death, and the particular dynamics of the relationship with the deceased can result in ‘complicated grief’ which may manifest itself in a number of different ways and which may necessitate medical or therapeutic intervention (Field & Filanosky 2010; Lendrum & Syme 2004; Neimeyer 2001, 2005; Rando 1993; Worden 1983, 2010).

In order to trace the historical development of thanatology, we must begin with Freud’s (1915[1917]) seminal work *Mourning and Melancholia*, a work that has been of major significance in shaping Western socio-cultural understandings and discourses related to bereavement and the grieving process. In this paper, Freud identified the (psychoanalytically-derived) characteristics of mourning, the main tenet of which was predicated on the principle that ‘successful’ grieving entails the severing of all emotional ties to the deceased through a process of ‘decathexis’ in order that new relationships could be established – in other words, ‘recathexis’. If the bereaved person was unable to successfully decathect from the deceased through ‘grief work’ this could, Freud believed, indicate pathological grief. Interestingly, given the fact that Freud’s model of ‘grief work’ has become the dominant model of grieving in Western society, some commentators have observed that it was not necessarily Freud’s intention to identify a definitive model of the grieving process and that his work has been subject to misinterpretation (Browning 2003; Hagman 2001; Rando 1993; Valentine 2006).

The influence of Freud’s (1915[1917]) work however, was pivotal in the construction of various ‘stage’ or ‘phase’ models of the grieving process, the first of which was proposed by Lindemann (1944) following his observations of grieving individuals. From this research he identified three main stages of grief work, namely:

“emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is absent, and the formation of new relationships” (Lindemann 1944 p. 143). Lindemann’s stages of grief bore a remarkable similarity to Freud’s assertion that successful grief work involves a complete detachment from the deceased. Following Lindemann’s (1944) model, Kubler-Ross (1969/2009) identified a five-stage model of grief based primarily on her observed experiences of the dying rather than the bereaved, although her model was also used to identify stages of the grieving process. Subsequently, Bowlby (1980) drawing upon his important work on attachment theory identified four phases of grieving: numbness, yearning, disorganisation and despair, and recovery - which he later termed ‘reorganisation’ in recognition of a continuing bond with the deceased.

Some years later, Worden (1983, p.11) moving away from the delineation of a sequential stage model - although still emphasising a ‘grief work’ approach - posited a model of grieving based instead upon the ‘four tasks of mourning’, the successful accomplishment of which was necessary to enable the bereaved to readjust to a life without the deceased. In the later editions of this work however, Worden (2010) revised his fourth task from one that required a withdrawal of energy from the deceased to one that advocated finding an ‘enduring connection’ to the deceased. In a move towards viewing grief as a process, Rando (1993) in her seminal text on complicated grief, defined what she termed the ‘Six ‘R’ processes of mourning. Rando (1992) deliberately used this term to distinguish it from Worden’s term ‘task’, thus recognising that grief does not follow a developmental sequence that may or may not have specific outcomes. Most importantly, Rando (1983) acknowledges that establishing a new relationship to the deceased is not indicative of pathological grief.

In the last twenty-five years there has been a shift from a modernist to a post-modernist and social constructionist paradigm (Neimeyer, Prigerson & Davies 2002) that recognises the embeddedness of bereavement within a socio-cultural context, and that places greater emphasis upon the relational and 'meaning-making' aspects of bereavement. This has resulted in a reappraisal of what it means to mourn and has brought into question the efficacy of a model of bereavement based on stages or phases as being the only model that has credence (Center for the Advancement of Health 2004; Paletti 2008; Valentine 2006). For example, a number of research studies (Field 2006a; Klass 2006; Klass, Silverman & Nickman 1996; Stroebe & Schut 1999) challenge the notion of 'grief work' and the socially perpetuated discourse that emphasises decathexis, offering instead alternative ways of conceptualising the grieving process that take into consideration differing socio-cultural factors. Furthermore, new theories that challenge existing models of 'grief work' based upon empirical research studies (Stroebe & Schut, 2001; Wortman & Silver 2001), illuminate more clearly how the bereaved experience and cope with their loss in unique and individual ways.

Research studies on 'continuing bonds' (CB) (Field 2006a; Klass 1993, 2006; Klass, Silverman & Nickman 1996; Stroebe & Schut) has also been influential in challenging the notion that healthy adaptation to bereavement means severing all ties with the deceased. For example, Klass' (1993) work with bereaved parents exemplifies the importance to these parents of constructing an "inner representation" of their dead child (Klass 1993, p.345). In addition, recent research extends our understanding of the positive, transformational aspects of bereavement which can include greater compassion for, and understanding of others; maturity; increased independence and self-reliance; changes in perspectives on life; and greater inner strength (Bonnano 2004, 2009; Calhoun & Tedeschi 2001; Frantz, Farrell & Trolley 2001; Schaeffer &

Moos 2001). Greater recognition has also been given to the impact on the bereaved of different types of losses; for example, the death of a child, or death through suicide. Moreover, there has been an increased acknowledgement of the impact of those losses that are not socially sanctioned, such as death from AIDS or drug overdose, or where relationships between the deceased and the bereaved are not socially recognised (Lendrum & Syme 2004). These factors “may carry a stigma that inhibits survivors from seeking or receiving social support” (Doka 1999, p.38) and can lead therefore to what Doka (2002) terms ‘disenfranchised grief’.

From a social constructionist perspective, research by Attig (2001), Gillies & Neimeyer (2006), Holland, Currier & Neimeyer (2006), Neimeyer (2000, 2001, 2005), on meaning-reconstruction, sense-making and benefit-finding following bereavement makes a significant contribution to our understanding of the personal and existential aspects of loss and the importance for some bereaved individuals of making sense of the death. Furthermore, other recent research studies (Field 2006a, 2006b; Field, Paderna & Gao 2005) have contributed to our understanding of the relevance of attachment styles both in adaptation to bereavement, and in issues of complicated grief. Stroebe & Schut (1999, 2010), in an endeavour to propose an alternative model of ‘grief work’ that acknowledges the bereaved person’s ‘oscillation’ between the ‘loss-orientation’ and ‘restoration-orientation’ dimensions of grieving, subsequently identified a model of grief termed the Dual Process Model (DPM) of grieving. This work has been further developed by Machin (2009) in the form of her Range of Responses to Loss (RRL) framework. Finally, there is a growing body of research into the use of narrative in the grieving process, with researchers such as Walter (1996), Gilbert (2002) and Bosticco and Thompson (2005) attesting to the benefits for the bereaved of talking about the deceased, particularly as the “disembedding from place, from tradition and from kin”, (Walter 1996, p.15) as

reflected in some aspects of today's society, makes the availability of others for such conversations increasingly difficult.

Despite the developments in thanatology in the latter half of the 20th century and early 21st century, the "culturally endorsed paradigm of grief" (Browning 2003, p.330) is one that emphasises the importance of 'letting go', 'moving on' and 'finding closure' - phrases that have become idiomatic in Western society - a paradigm that constructs grief as a 'goal-directed activity' rather than a 'state of being' (Valentine 2006, p.59). This view is reinforced by the 'psychologising' of grief that reflects a discourse where the goal of 'grief work' entails the severing of ties with the deceased in order to 'recover' from the loss, a view which the medical profession reinforces. Recent research however, conducted within the context of a post-modernist paradigm, challenges some of these tightly-held assumptions and has led to a clearer understanding of the individuality of grief that can accommodate "mystery and contradiction in the grieving process" (Browning 2003, p.331).

(ii). Therapists' experiences of personal bereavement and its impact on professional practice.

Following an in-depth search of the literature, it became apparent that there is a dearth of source material on therapist bereavement. Fortunately, during my wider literature search I accessed a paper (in press at the time) via the University of Surrey research website that proved beneficial in informing my subsequent search strategy. This paper (Kouriatis & Brown 2011) comprises a review of the literature on therapist bereavement which I used as a basis for refining my search in the specific areas I wished to address. Several of the references cited were unavailable in the University library, so I used the Inter-Library Loan system to access sources. I also made extensive use of the University databases, COPAC, Google Scholar and ProQuest

Dissertations and Theses database. The small body of literature on therapist bereavement cited here falls into two main categories: (i) therapists' personal accounts of, and reflections upon, personal bereavement and its impact on their therapeutic practice; (ii) empirical research studies.¹ (Further details of the literature search can be found in Appendices 2-5: Tables 1-4, pp.81-84).

On first reading the literature on this topic, particularly the personal accounts of therapist bereavement, I was moved by the vivid depiction of the rawness and excoriating pain of loss that permeates the writing (Browning 2003; Callahan & Dittloff 2007; Chasen 1996; Felberbaum 2010; Gerson 1996; Lambert 2003; Mendelsohn 1996; Morrison 1996; Ryan 2007; Vamos 1993; Weingarten 2010). It is clearly apparent that the experience of the death of a loved one "permanently alters the survivors' internal and external worlds" (Ryan 2007, p.60), a view reinforced by Felberbaum (2010, p.271) who writes that it was not until her mother's death that she truly experienced "the internally focused, visceral understanding of grief". Common to all the personal accounts is the overwhelming and unrelenting nature of grief (Chasen 1996; Ryan 2007) and the painful recognition that it is not a linear process. There is also a strong theme related to the effect of bereavement on one's sense of self, powerfully illustrated by Rappaport (2000, p. 57) as she describes how her husband's death "stripped me from the moorings of my life", forcing her to reappraise her previously held assumptions and beliefs, whilst Callahan (Callahan & Dittloff 2007, p. 548) movingly describes how she felt an "immediate personal understanding of suicide" following the still-birth of her child. Similarly, Dittloff (Callahan & Dittloff 2007) describes how his daughter's death resulted in a profound existential crisis, rendering him vulnerable for the first time in his life.

¹ The literature reviewed here does not refer to the death of a client and its impact on the therapist. This is outside the specific focus of this study.

One of the first academic papers to address the topic of therapist bereavement was written by Givelber & Simon (1981). Although not based upon empirical research, the authors discuss the anecdotal experiences of bereaved colleagues and the effects on their therapeutic practice. In a number of respects this early study identified themes that arise in subsequent studies (Bozenski 2006; Hayes, Yeh & Eisenburg 2007; Millon 1998), and in the personal accounts cited here. These include issues regarding grief-related affect, and the impact on aspects of professional functioning and therapeutic practice. The first empirical, qualitative research study was carried out by Millon in 1998. Her study was the first to systematically explore how the bereavement experiences of ten psychodynamic therapists impacted upon their therapeutic practice. Consistent with the personal accounts cited above, Millon (1998) found a wide range of grief-related emotions expressed in her participants' narratives including feelings of numbness, dissociation, dislocation, distortions of time, overwhelming sadness and loss, and changes to world view and sense of self. Interestingly, she also found evidence to suggest that the participants were influenced by the dominant socio-cultural model of grief as evidenced in the participants' statements that they should 'get over it' more quickly than was possible (Givelber & Simon 1981; Hedtke 2002; Walsh 2004).

In terms of the impact of therapists' bereavement on their professional lives, several common themes emerge from the literature. For example, it was found that some therapists decided to resume their practice while still actively mourning the death of their loved one (Givelber & Simon 1981), often not anticipating that grief is not experienced as a linear process, but rather that one "dips in and out of cycles of acute and less acute grief" (Lambert 2002, p.27). This decision was influenced in part by the therapists' need for structure and consistency, the need to feel useful, and the need for companionship (Millon 1998). In Chasen's (1996, p.8) case however,

returning to work was seen primarily as an important 'survival' strategy to ameliorate the pain and the void left by her young son's sudden death, a decision that could have raised ethical issues regarding fitness to practice. Having resumed their practice, and therefore within the context of their continuing in-session work with clients, these therapists experienced a range of differing emotions including fear of being overwhelmed by their grief (Millon 1998), avoiding engagement with specific client material (Chasen 1996), over-identification with client material (Warshaw 1996) and preoccupation with their own loss (Hayes, Yeh & Eisenburg (2007). It is worth noting that there is a significant lack of reference to either personal therapy or supervision in these accounts, although Chalmers (2009, p.188) does refer to the fact that where parallels exist between therapist and client work, "Supervision that is both challenging and supportive" is invaluable.

Another major theme in the literature is that of self-disclosure (Chasen 1996; Givelber & Simon 1981; Mendelsohn 1996; Millon 1998; Small 2000). Several therapists struggled with this dilemma and demonstrated a high level of anxiety regarding what, if anything, to disclose to clients regarding the therapist's absence. This was exacerbated for psychoanalytically-orientated therapists due to their desire to remain neutral, protect boundaries, and avoid disruptions in their work with clients' transference issues. The decision not to self-disclose also served a self-protective function coupled with a desire to preserve a façade of strength to support clients. (Vamos 1993). Therapists who self-disclosed to some of their clients received a variety of reactions ranging from hostility (a rare response) to empathy, compassion and human support (Chasen 1996; Morrison 1996). A minority of clients however, did not feel able to work on their own process in light of their therapist's experience (Chasen 1996; Guy 1981; Mendelsohn 1996). Interestingly, some of the participants in Millon's (1998) study reported that despite an absence of self-disclosure, their

clients had nonetheless noticed instances of therapist inattentiveness and preoccupation, a state Millon (1998, p.137) describes as being “psychically detached”. Of those therapists who decided to disclose, most appear to have found it a positive experience and one that resulted in a “deepening of the mutual appreciation of what we share as people” (Mendelsohn 1996, p.26).

Another significant theme emerging from the literature suggests that therapists’ experiences of bereavement can be personally transformative and can have a positive impact upon clinical work (Bozenski 2006; Browning 2003; Callahan & Dittloff; Chalmers 2009; Givelber & Simon 1981; Hayes, Yeh & Eisenburg 2007; Menos 2004; Millon 1998; Walsh 2004). For example, several therapists in the literature cited here experienced a heightened sense of empathy and attunement with their clients (Bozenski 2006), an increased awareness of existential issues connected to life and death (Gerson 1996; Millon 1998), and an ability to respond to client loss in a “keener and more sensitive way” (Givelber & Simon 1981, p.143). Indeed, Chalmers (2009, p.188) describes how her experience of losing a child resulted in “an immense transformation in relation to my long-held fears of matters of death and dying” and “enhanced my ability for empathy and understanding”. Similarly, Small (2000) writes that through the strength and inner resources she has discovered in herself, she now searches for these in her clients. For the participants in Millon’s (1998, p.132) study, an increased understanding of the pain associated with grief was translated into therapeutic practice with clients through the ability to “be there and help them bear an intolerable reality”, whilst Lambert (2003, p.37) affirms that her own counselling practice benefited from her “heightened awareness of the importance of openness and integrity of thought and feeling”.

It is however, important to recognise that this process of healing and transformation is just that – a *process*, and one that evolves over time. Thus, in order for the therapist to heal the client's wounds, she must first heal her own (Wheeler 2007). Hayes, Yeh & Eisenburg's (2007) quantitative research study involving sixty-nine participants is of particular interest in this regard as it investigates differences in the length of time since the therapist's bereavement and the consequent impact on therapy. The therapists involved in their study had to be working with death-related issues and clients' perceptions of the therapeutic process were also assessed. The main finding to emerge from the data supports the view that "when therapists' emotional energy is tied up in an unresolved personal issue such as grief, clients may perceive them to be less available and less understanding" (Hayes, Yeh & Eisenburg 2007, p.351). Conversely, the study found that when therapists had resolved their own grief issues, they were perceived as being *more* empathic.

This literature review provides a theoretical lens through which the data analysis and the participants' experiences of bereavement can be viewed. It is clear from the literature that the process of grieving can be conceptualised and manifested in a variety of ways. It may be possible therefore, to identify commonalities and differences between the theory and the lived experiences of the participants in this study that will further illuminate the essence of what it means to mourn, and further inform our understanding in terms of therapeutic practice.

CHAPTER THREE: METHODOLOGY

Philosophy, design and rationale

That research is invaluable in increasing our understanding of the complex nature of counselling and psychotherapy, there is little doubt (Cooper 2008; Harper & Thompson 2012; Jordan 2000; McLeod 1999, 2003a, 2011; Silverman 2000). Both quantitative and qualitative research studies can serve to develop and enrich this understanding. Indeed, the practice of research itself has evolved, moving away from the dominance of positivist approaches founded upon a scientific epistemology which favoured quantitative methodologies, through “the moment of blurred genres” (Denzin & Lincoln 2003, p. 24) and toward an embracing of qualitative methods of research that are situated within philosophical traditions such as phenomenology and hermeneutics. One such qualitative research method is exemplified by Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin 2009), the selected methodology for this study.

For any type of research project the researcher must be clear about which epistemological and ontological philosophies underpin and inform all aspects of her research, since it is the researcher’s philosophical stance that will determine her view of reality and knowledge acquisition (Willig 2008). The positivist paradigm for example, assumes that there is one universal truth that can be proved or disproved. Hypotheses are generated and tested through the use of quantitative research methods that utilise large samples of participants and standardised measures of testing. Data from questionnaires for example, are analysed in terms of statistical outcomes that can be generalised to a wider population (Flick 2009). Conversely, qualitative research methods are underpinned by the philosophies of phenomenology and hermeneutics and no attempt is made to test an *a priori* hypothesis. These

particular paradigms question the ontological notion of a 'fixed reality' believing instead that knowledge is co-constructed within a socio-cultural context in which the individual's subjective perceptions, meanings and understandings are of prime importance, a view that has strong resonances with a post-modernist, social constructionist paradigm (Giorgi & Giorgi 2008; Langdridge 2007; McLeod 2003b; Neimeyer & Hogan 2001; Smith 2008). Qualitative research is reflective; it is naturalistic; it seeks to understand the *essence* of the phenomenon, and focuses on "the meanings through which people construct their realities" (McLeod 2001, p.2). Moreover, there is a complementarity between the principles underpinning a phenomenological research perspective and humanistic psychotherapy (Strong, Pyle, de Vries, Johnston & Foskett 2008) in that both foreground the lived experience of the individual in an endeavour to enhance understanding. This view is consonant with the person-centred philosophy that underpins my practice, and also with postmodernist developments in bereavement research (Carverhill 2002; Jordan; Silverman 2000; Stroebe, Stroebe & Schut 2003).

'Phenomenology', from the Greek root meaning to 'show itself' or "bring to the light of day", (Heidegger 1962, p.54) is both a philosophy and a method. It is necessary at this point to provide an overview of this philosophy as well as to explain its somewhat paradoxical relationship to hermeneutics, particularly as IPA is a methodology that combines elements of both philosophical approaches. (Larkin, Watts & Clifton 2006; Smith & Eatough 2007; Smith & Osborn 2008). Although there are several variants of phenomenological enquiry (Langdridge 2007) the philosophy of phenomenology is rooted in the writings of Husserl (1927) the 'father' of phenomenology and Heidegger (1962). Husserl (1927) formulated what is known as '*transcendental phenomenology*', a way of looking at the everyday world and our experiences within it and, through a close examination of that experience, endeavouring to discover its

essential qualities. (Larkin et al 2006; Moustakas 1994; Smith et al 2009). Central to phenomenology is the notion of *intentionality* that recognises that “The life-world manifests itself as a structural whole that is socially shared and yet apprehended by individuals through their own perspectives” (Wertz 2005, p.16). To facilitate an exploration of this ‘life-world’ the researcher must therefore ‘bracket off’ his or her prior assumptions and preconceptions and “practice an *epoche*” (Husserl 1927, p.4), a “radical act” (McLeod 2001, p.51) that involves “retaining a wonder and openness to the world while reflexively restraining our pre-understandings” (Finlay 2008, p.1).

There appears however, to be a contradiction between the epistemological positions of phenomenology and hermeneutics which necessitates some explanation. The kernel of this paradox lies in the fact that in hermeneutics - the theory of interpretation - understanding is always interpreted from a particular perspective, whereas phenomenology seeks to set aside assumptions and come to a description of the essence of the thing itself (McLeod 2001). IPA is a methodology that draws upon both phenomenology and hermeneutics, and to further explore this relationship we must consider the philosophical writings of Heidegger (1962) and Gadamer (1975/2004). From an historical perspective hermeneutics was concerned with the interpretation of texts, particularly religious texts, but has developed to include the interpretation of a wider range of textual material (Smith et al 2009).

In terms of the interrelatedness of phenomenology and hermeneutics, Heidegger (1962) offers a cogent synthesis. Firstly, Heidegger (1962, p.65) recognised the situatedness of human existence, a state he refers to as *Dasein* or ‘being-in-the world’, saying that we are ‘always already’ thrown into a “pre-existing world of people and objects, language and culture” (Smith et al 2009, p.17) which is temporally defined and from which we cannot be meaningfully separated. Moreover, Heidegger,

(1962, p.191) diverging here from Husserl, posited that it was impossible to suspend our own preconceptions and that, in terms of hermeneutic enquiry, these comprised a 'fore-having', that constitutes an interpretive framework for understanding the world we inhabit. With regard to a more contemporary understanding of the historical and traditional situatedness of *Dasein*, Gadamer's writings have much to offer in support of Heidegger's philosophy. Gadamer (1975) suggests that we all exist within the constructs of our own 'horizons' which are historically, culturally and linguistically bounded. Therefore, when engaged in an act of interpreting and understanding a text, Gadamer (1975, p.305) suggests that there is a 'fusion of horizons' that involves "the coming together of the historical understanding of the world of the interpreter and that of the text" (McLeod 2011, p.29).

Whilst phenomenology and hermeneutics might seem to be philosophically opposed, there are, as McLeod (2001, p.57) observes, "significant areas of convergence" in that both paradigms "assume an active, intentional, construction of a social world and its meanings by reflexive human beings", and both deal primarily with linguistic material. Thus, in order to reconcile the epistemological tensions between the two paradigms, a balance must be found. A reliance on hermeneutics alone to analyse a phenomenon means incorporating our understanding of the phenomenon into "a model or theory that already exists", (McLeod 2001, p.58) whereas phenomenology, by virtue of the fact that it suspends taken-for-granted assumptions, pushes the boundaries in search of new meanings of that phenomenon. As Smith et al (2009, p.37) observe: "Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen".

IPA, whilst being a 'young' methodology and one that is exemplified primarily in health-related research (Brocki & Weardon 2006; Reid, Flowers & Larkin 2005),

nonetheless has a distinguished provenance (Eatough & Smith 2008; Smith 2004, 2007, 2011). The method is underpinned by the central tenets of Heideggerian phenomenology and has at its core the life-world of the participant. Furthermore, it recognises that participants are situated within an historical, socio-cultural, and political milieu and that individual meaning will be constructed - and therefore interpreted - within this context. IPA remains true to the fundamental notion that individual meanings emerge from the data in an inductive way, and recognises the reflexive role of the researcher in operating a 'double hermeneutic'; that is, the researcher trying to make sense of the participants' trying to make sense of their experience (Smith et al 2009, p. 35). In terms of this study, IPA was considered to be the most appropriate methodology for the exploration of the lived experiences of a small sample of bereaved therapists in order to achieve an "authentic and comprehensive description of the way in which a phenomenon is experienced by a person or group of people" (McLeod 2003b, p.79), that "may be relevant to others and take intersubjective thinking further" (Todres 2007, p.27).

Sampling

In quantitative research the sample is selected in order that nomothetic (universal) generalisations can be made (Dallios & Vetere 2005) and sample sizes usually represent a large proportion of the population. In qualitative research however, and in IPA specifically, the aim is to build a homogenous sample consistent with an idiographic approach (Larkin & Thompson 2012; Smith et al 2009) in order to gain a "deep understanding of some phenomenon experienced by a carefully selected group of people" (Maykut & Morehouse 1994, p. 56). The sampling procedure employed in this study was therefore a purposive sampling strategy consistent with the study's phenomenological perspective that aimed to "capture both the

uniqueness of meanings relating to [the] phenomenon as well as commonalities” (Dallos & Vetere 2005, p.41). Recruitment was by advertisement in the BACP journal *Therapy Today* and via the BACP Research website. (Appendix 7, p.86).

Criteria for inclusion

As one of the main foci of this study is the experiences of bereaved humanistic therapists (as distinct from the experiences of psychodynamic therapists cited in the literature) this was a main ‘fixed’ criterion for inclusion. Another important criterion - and also an ethical consideration given the sensitive nature of the research topic - was that a period of one year should have elapsed since the bereavement. In this regard, it was hoped that participants would have acquired a sufficient degree of distance from the emotional immediacy of the event to enable discussion of their experience without becoming overwhelmed. It was also important that participants should not be receiving therapy in respect of this issue. Following the first pilot interview, the criterion of ‘not more than five years’* was considered unnecessary given the evolving nature of the grieving process over time, and therefore removed. Participants had to be currently practising members of BACP, and receiving regular supervision. Criteria for inclusion were as follows:

Participants should:

- hold a graduate/postgraduate Diploma in Counselling, and/or a higher degree in Counselling or other equivalent qualification
- be a full or part time practising therapist working from a fundamentally humanistic/person-centred orientation
- have been practising for at least two years
- be receiving regular supervision
- be a member of BACP

- be able to converse with reasonable fluency in English if English is not home language
- have had a period of at least one year since the personal bereavement

Open variables were gender, ethnicity, length of time in practice, type of practice and client base, relationship to the deceased, and type/circumstances of the death.

Participants' ages fall within in the 35-55 age range.

Following initial responses from possible participants, I sent a short letter to each respondent thanking them for their interest (Appendix 8, p.87) and enclosing an information sheet (Appendix 9, pp.88-90) and short questionnaire based upon my inclusion criteria. (Appendix 10, p.91). The information sheet provided a detailed explanation of the nature of the research project, its rationale, potential risks and benefits to participants, and the participant's role in taking part in a digitally-recorded interview. This level of detail was crucial given the sensitive area being studied and the imperative to obtain informed consent. I also referred briefly to my own experience of bereavement thus situating me as an 'insider' in relation to the topic (Roulston 2010). The participant's right to withdraw at any time during the research process was emphasised (Research Governance Handbook, p.12:36.4).

On receipt of the completed questionnaires, the respondents were sent a letter inviting them to participate in the study. (Appendix 11, p.92) Accompanying this letter was a 'Research Consent Form' (Appendix 12, p.93) and a 'Consent to Digital Audio Recording of Interview Form' (Appendix 13, p.94). Prior to the interview, participants were invited to a pre-interview meeting in order to clarify details of the research. It was also suggested that participants inform their supervisors of their participation in the project. Having received the completed consent forms, I arranged dates and

times for the interviews. None of the four participants felt it necessary to have a pre-interview meeting, and those minor details that needed clarification were addressed via email or telephone. The sample used in this study comprises the four respondents who demonstrated an initial interest in taking part in the study, all of whom met the inclusion criteria. (Appendix 14: Table 6, p.95).

Data collection procedures

We live in what might be termed an 'interview society' in which interviews are used extensively to acquire information on a multitude of topics. Moreover, interviews are wide-ranging in form and structure and therefore the choice of interview as a method of data collection must be fit for purpose and take into consideration its relational and contextual features. In this regard, Schwandt (1997, p.79) [as cited in Fontana & Frey 2000, p.663] suggests that interviews can be seen as "contextually grounded and jointly constructed by interviewer and respondent". The researcher assumes the role of a 'craftsman' (Kvale & Brinkman 2009, p.166) who enables the participants to provide "in-depth descriptions of the life experiences of interest to the researcher" (Roulston 2010, p.18) within a supportive environment. It was crucial therefore that I endeavoured to offer the core conditions (Rogers 1957) when listening to my participants' moving stories as "A person-centred approach is most appropriate when the aim is to achieve a deep understanding of the experience of the research respondents" (Wilkins & Mitchel-Williams 2002, p.300).

In IPA the semi-structured interview is considered the most appropriate means for obtaining the participants' "rich, detailed, first-person account of their experiences" (Smith et al 2009, p. 56), and in terms of this phenomenological study, the use of interviews succeeded in facilitating access to the "deeper perspectives that can be captured through face-to-face interaction" (Marshall & Rossman 2011, p. 91). The

interview explored two main foci: (i) the participant's experience of personal bereavement; and (ii) its impact on their therapeutic practice. Prior to the interview, the participants were sent a copy of the interview schedule (minus prompts) as a 'guide'. (Appendix 15, p.96). In IPA it is important that the researcher is flexible enough to allow the participant to explore areas of significance to her, rather than rigidly follow a prescriptive format (Eatough & Smith 2008), and therefore my questions were designed to be "open and expansive" (Smith et al 2009, p.59) with sensitive topics being placed later in the schedule. Although the questions were influenced in part by the extant literature, I endeavoured to maintain an open attitude, free, as far as possible, from preconceptions or biases. Following feedback from the first pilot interview with a colleague, I amended the schedule and this version was subsequently used in the second pilot and participant interviews. (Appendix 16, pp.97-98.) The participant interviews ranged in length from fifty minutes to two hours, were conducted in a location of the participant's choosing and were digitally recorded.

Data analysis

The method of analysis used in this study is Interpretative Phenomenological Analysis (IPA), the aim of which is to explore in detail how participants make sense of their personal and social worlds. It is a "dynamic process with an active role for the researcher in that process" (Smith & Osborn 2008, p.53). IPA is an idiographic methodology that begins with the particular (a case study of one participant) and then builds up themes (Larkin & Thompson 2012; Smith 2011). It is an inductive and iterative approach that requires a sustained engagement in an "interpretative relationship with the transcript" (Smith & Osborn 2008, p.66). In terms of levels of interpretation, IPA employs a "hermeneutics centred in empathy and meaning

recollection”, but also allows a “hermeneutics of questioning” (Smith 2004, p.46). IPA researchers operate what is referred to as the ‘hermeneutic circle’ (Schleiermacher 1975; Smith et al 2009) a process through which any given part is understood in relation to the whole – and vice versa. The researcher moves back and forth between the data in an iterative process of understanding and interpretation that is constantly being refined, resulting in a fine-grained analysis (Eatough & Smith 2008). (See Appendices 17-30, pp.99-105 for a detailed procedural overview of the data analysis interspersed with extracts from my Reflective Research Journal).

Following completion of the interviews, the digital recordings were transcribed verbatim. Firstly, the transcripts were read and re-read in order to gain a ‘feel’ for the overall content. Secondly, exploratory comments on the descriptive, linguistic and conceptual aspects of the transcript (Smith et al 2009) were made in the right-hand margin. These comments represented the ‘initial coding’ of the transcript.

(Appendices 18, 19, 22: Tables 7, 8, 11, pp.106-111; 120-122). Thirdly, the initial codes were used to document emerging themes in the left-hand margin. (Appendices 20, 21, 23: Tables 9,10,12, pp.112-119; 123-126). Next, emerging themes were typed up in chronological order of their appearing in the transcript, cut out, arranged into ‘clusters’, and then stuck (or copied) onto large sheets of paper (Smith et al 2009, p.96). This facilitated a visual and spatial exploration of how the themes related to each other. It also enabled me to reallocate particular themes and disregard others. (Appendices 24, 25: a,b,c, pp.127-132). Finally, I produced a table identifying the superordinate and sub-themes for each participant, together with illustrative in vivo quotes and page/line references. (Appendices 26-29: Tables 13-16; pp.133-136) The above process was repeated for each participant’s transcript, allowing new themes to emerge with each case. Once this had been achieved, I then looked for patterns, connections and differences across all four cases in an attempt to arrive at

a table of master themes that represented the data set as a whole. (Appendix 30: Table 17, pp.137-138).

Ethical issues

All ethical research is “grounded in the moral principles of respect for persons, beneficence and justice” (Marshall & Rossman 2011, p.47).

A consideration of ethical issues permeates the research process as a whole (Creswell 2009) and therefore the researcher must be prepared to deal with unexpected issues in an ethical manner. The first step in this process was obtaining approval for the study from the Ethics Committee at the University of Chester. As a member of BACP I adhered throughout my research to the principles of beneficence and non-maleficence (BACP 2010, p.3) and acted in accordance with the Ethical Guidelines for Researching in Counselling and Psychotherapy (Bond 2004). The rationale and purpose of the study was made clear to participants from the outset in order to ensure a mutually agreed agenda, and criteria for inclusion were clearly identified. Informed consent was obtained from participants (Bond 2004; Research Governance Handbook p.11:34) and the right to withdraw without explanation was emphasised throughout the research process. Dual relationships with participants were avoided.

Due to the sensitive nature of the topic, participants were invited to a pre-interview meeting, and were sent a preview of the interview schedule prior to the interview proper. Within the interview context I endeavoured to be fully present to the participants and offered the core conditions (Rogers 1957) in order to establish rapport and trust. Following the interviews, there was a ‘de-brief’ and participants were provided with sources of support relevant to their geographical location. (Appendix 31). Confidentiality was assured, and interview transcripts and data arising

from these were anonymised using a coding system and self-selected pseudonyms. Further, participants were invited to 'member check' transcribed material to ensure accuracy. Assurances were given that all audio-recordings and other material would be destroyed. Similarly, details regarding the ownership, readership and retention of subsidiary data, were clarified. All data were kept securely and all computer-generated data were password protected. Every attempt was made to ensure transparency and integrity at all stages of the research process, including writing up (Bond 2004). Moreover, careful consideration was given to the specific ethical issues regarding bereavement research (Cook 2001; Parkes 1995; Stroebe, Stroebe & Schut 2003).

Potential benefits to participants

As the focus of this study is an under-researched area in a number of ways, the research served to 'give a voice' to the participants and in that sense was an empowering experience (Cook 2001). Through the opportunity to reflect upon past experience, albeit a painful one, participants were able to perceive their individual 'stories' in a reconstructed or modified way. All four participants attested to the benefit of having their narratives 'witnessed', and there was a clear sense that in the here-and-now of the telling, new insights had been brought into awareness (Beck & Konnert 2007). Moreover, the participants gained some degree of therapeutic benefit from their involvement in this process (Birch & Miller 2000) which provided an opportunity outside of supervision or personal therapy for an in-depth reflection on the ways in which their experience of bereavement informs their therapeutic practice.

Potential harm to participants

The focus of this research constituted a sensitive area and thus there was the potential for participants to become distressed, particularly during the interviews

where painful memories or unresolved issues might have arisen (Cook 2001). However, the contextual immediacy of the interview situation allowed for its termination, and the option to terminate *at any time* was made clear to all participants. As is recognised in the research (Bond 2004; Cook 2001; Parkes 1995; Stroebe, Stroebe & Schut 2003), the wellbeing of the participant is paramount. My own personal and professional experience of bereavement was also helpful in that I was able to offer a high degree of empathy to participants and remain in their frame of reference. In order to mitigate potential distress following the interview, there was a 'de-brief' and participants were provided with a comprehensive list of sources of support relevant to their geographical location. (Appendix 31, p. 139).

Validity and trustworthiness

The distinct differences that distinguish qualitative from quantitative research mean that issues of validity and trustworthiness must be conceptualised differently. For example Yardley (2008, p.237) suggests that rather than trying to rigidly control the research process, "qualitative researchers generally seek to maximise the benefits of engaging actively with the participants in the study". This point recognises that the qualitative researcher inevitably influences and shapes the research process both as a person and a theorist (Willig 2008). With regard to IPA, Smith et al (2009) concur with Yardley's (2008) criteria for assessing validity and also with Elliott, Fischer & Rennie's (1999) guidelines for the publication of qualitative research. Furthermore, Smith (2011) offers his own criteria for evaluating IPA studies. In terms of generalisability - which is more difficult to achieve in qualitative research - McLeod (2003b, p.87) suggests that the reader must recognise the set of experiences being described as "authentic and credible". Eatough & Smith (2007, p.40) suggest that it is possible to think in terms of "theoretical rather than empirical generalizability"

where the reader makes links between her own experience, the findings of the IPA study and the literature, a point with which Morrow (2005) concurs. Thus, the impact of an IPA study “is judged by the light it sheds within this broader context” (ibid, p.41).

In terms of this study therefore, validity has been demonstrated through:

- a research design that demonstrates a “coherent line of reasoning and internal consistency” (Punch 2000, p.11)
- an adherence to ethical considerations related to research into sensitive issues
- offering detailed information to participants about the context of the study and the procedures employed
- ‘member checking’ of transcripts and ‘participant information’
- acknowledging personal biases
- maintaining a reflexive research journal
- maintaining a detailed audit trail of the evolving process of data analysis
- demonstrating the extent to which themes and interpretations are grounded in the data
- the consistency in the themes identified in the pilot interviews with those that emerged in the participant interviews
- using supervision and ‘peer checking’ of emerging themes and researcher interpretation
- maintaining professional credibility as a researcher at all stages of the research process

The next chapter will present a detailed account of the findings that emerged employing the methodology detailed above.

Not every participant contributed in the same way to each master theme; rather their contributions constituted a unique manifestation of a particular sub-theme – and therefore a divergence – whilst retaining convergence at a higher level of abstraction. The four themes are considered below with reference to relevant participant quotes. The richness and density of the data however, has necessitated some selectivity.

Participant information

The participants are referred to throughout the study by self-selected pseudonyms to preserve anonymity.

Goldie is an experienced humanistic/eclectic therapist who works in private practice. Goldie works with a range of presenting issues including anxiety, depression, relationship issues and bereavement. Following a stroke her mother, who lived abroad, developed dementia and died eighteen months ago.

Harper is a person-centred therapist who works with adults, and with young people in schools. Eight years ago, shortly before beginning her counselling training, Harper's husband died of a heroin overdose leaving her with three young children. Prior to his death, Harper had separated from her husband due to increasing tensions in the marriage, her husband's abuse of alcohol, and her feeling that it was unsafe for her and her children to stay.

Jessica works as a person-centred therapist in private practice with a specialist interest in bereavement, relationships, and disability-related issues. Jessica's second child was born with heart problems and Jessica was forced to make the decision to switch off her daughter's life support. She later discovered that her

daughter's organs had been used in the 'organ retention' scandal that was widely publicised in the media at that time.

Sophie is a humanistic therapist working in private practice. She works with adult individuals and couples on a range of presenting issues. Five years ago - and two years after qualifying as a therapist - Sophie's husband died suddenly from a heart attack during a family holiday, leaving her with their two-year old son.

The significance of Time

It is important to explain that whilst time is not a major theme per se, the four master themes are contextualised within a temporal framework that reflects not only the evolving process of grief, but also the personal and professional development that has occurred in the lives of the participants since their individual bereavements. Indeed, the research interview itself constituted a significant event in each participant's process, enabling her to employ a self-reflective hermeneutic circle, thereby achieving an increased understanding of her whole narrative through a reflection on its constituent parts. Throughout their narratives all the participants provided temporal markers and these gave their accounts a cohesive structure and situated the bereavement event within the specific circumstances leading up to, and following it. Thus there was a clear sense of a 'before' and 'after' that permeated the four master themes, exemplified by the participants' use of temporal linguistic phraseology.

Note: The thematic analysis does not follow the chronological order of the transcripts. Participant in vivo quotes have been edited for clarity, and are italicised.

Master Theme 1: *Bereavement as a unique experience*

Sub-themes:

- ***Affective impact of bereavement and the evolving grieving process***
- ***Impact on self, social identity, beliefs and world view***

Bereavement is both a universal and a unique experience. The findings from this study clearly reflect the veracity of this statement in that the experiences of all four participants, whilst sharing some similarities, were all very different. These differences related to the circumstances surrounding the death itself, the nature of the relationship with the deceased, the challenge to the assumptive world, and the impact on sense of self and social identity. The uniqueness of the experience for the individual participant - the 'essence' of the experience - is captured in the differing ways the data comprising the sub-themes are manifested.

Sub-theme (i): Affective impact of bereavement and the evolving process of grieving

There is no doubt that the experience of bereavement for all four participants was a significant, life-changing experience, and the participants reported a range of affective responses to the initial impact of the death which bear testament to the various ways grief can manifest itself. In the following extract Jessica vividly describes being powerless to prevent her baby daughter's life support being switched off, her subsequent death and the psychological effect of this experience:

I felt completely catapulted to a different realm from others where I felt other people just would and could never tread ..I was left over there and we'd see each other but I didn't feel that we were almost connected any more .. It all felt too harrowing .. Jessica

Some years later after having '*worked through*' this trauma, Jessica discovered that her daughter's organs had been used for organ donation, and she uses the same metaphor to describe how she was '*catapulted back to all the pain that had become reasonably comfortable*'.

For Sophie, the sudden death of her husband evoked seemingly contradictory emotions including shock, amnesia, and a feeling of peace.

*It was completely unexpected .. So the next three days I still can't remember at all what happened. I have no memory at all. At the moment he died .. I thought it's time for you to go and get some peace now, and not a lot has **changed** about that... The **biggest** thing I remember is exhaustion ... Sophie*

Goldie's deep sadness is tinged with regret at not having been able to travel abroad sooner, and not alerting her mother to her (Goldie's) presence.

*So when I **got** there I didn't really **know** whether she knew I was there or not. (Strongly) To this day I regret not saying something like "If you know I'm here squeeze my hand or something"... So I never really **felt** I got to ever say 'goodbye' to my mother. (With emotion) And I **miss** her. **So much.** Goldie*

Harper too experienced '*mixed feelings*' upon being told of her husband's death, feelings that she quickly suppressed:

*So there was part of me that was oh, **thank goodness**, he can't hurt me, he can't hurt the kids ... **Nothing** was going on emotionally. There was a part of me that was right, okay, he's not going to come round and cause any more hassle, but .. I wasn't emotional. Harper*

In terms of the grieving process itself, the participants referred to the continuing and changing nature of the process *over time*, a process mediated for some by personal

therapy, training, and continued personal and professional development. In some instances participants reflected upon the continuing bond with their loved one.

*So I've re-welcomed her to my heart .. it's carrying on **with** her.. Jessica*

It's an on-going process .. My relationship with my husband and his death changes over time. Harper

Sophie however, reflecting upon the paradoxical nature of the process, was aware that although many aspects of her life had 'moved on', the death itself remained fixed in time.

*It's frozen. It's still the 'death scene' in **my** mind... Even though everything has changed, **that's** remained frozen. Sophie*

The grieving process for Goldie had begun *prior* to her mother's death due to her mother's increasing dementia and, eighteen months after the actual bereavement, Goldie's grief is clearly raw and painful. She was however, trying to maintain a connection with her mother through a greater awareness of their shared characteristics.

*I was starting to mourn my mother for two, three years ...I'm still grieving ... It's like there's a parallel with my mother **going** and me **taking on** more of the traits that perhaps other people saw in her. Goldie*

For some of the participants, there was a sense that the evolving process of grieving had resulted in a re-awakening of something that had 'died' or lain dormant since the death. For example:

I sense that my spirit was squashed for a while, definitely, but then it's re-awakened and re-emerged in a strengthened way... Jessica

But the exhaustion, I'd say I've only come out of that in the last six months. I feel more like the old me for the first time in five years ... Got

energy back again. It's working with energy rather than working with a tank empty kind of feel. Sophie

It was also clear that part of the evolving process of grieving for the participants was their continuing struggle to make sense of their loss. For Goldie, the loss of her mother made sense because it was in *'the natural order of things'*, whilst Harper engaged in a continuing process of questioning and reflection.

(Slowly and reflectively) It's a gradual process because I wasn't used to communicating with that emotional side of me... So as my walk and my journey has developed and changed ... I've been able to get my head round stuff that doesn't make sense, even say I'll never know why ...

Jessica tried to make sense of her loss by seeking an acknowledgement from the hospital of the injustice done to her daughter (which she received), and then to write a book about her experience. In the book she included a poem about her daughter in which she used the image of a slowly-burning candle to represent her daughter's short life and tragic death, and also her continuing bond with her daughter.

*'We never saw its full potential, the sacred flame of life had been extinguished .. But I realise now ... her spirit endures'... That for me is what I can hold. Yes, that **exactly** sums up how I made sense of my loss.*

For Sophie, 'making sense' of her loss entailed accepting that it did not in fact make any sense within her present understanding.

*It would feel like putting some kind of logical ... I feel it's not right for it. I feel I've got to **accept** that it doesn't make sense.*

Interestingly, at the very end of our interview, whilst reflecting upon the telling of her story, Sophie articulated an important of-the-moment insight when she said:

... I found myself talking quite eloquently and that's good actually ... listening to myself speak, it's really quite nice to think that it does all make sense in a loony kind of way.

Sub-theme (ii): Impact on self, social identity, beliefs and world view

A prominent sub-theme that emerged from the study was the impact of the bereavement on the participants' internal sense of self and social identity, together with challenges to their beliefs, world view and prior assumptions. These however, were given varying degrees of emphasis by each participant. Sophie for example, spoke of how being given the 'cold shoulder' by her friends following her husband's death was 'totally shocking' and left her feeling '**really** let down and unsupported', forcing her to relocate to another area with her young son. The following extract powerfully illustrates her feeling of exclusion from a socially-embedded community of which she had previously been part.

*But it's life **after** it, ~~the~~ life as a young widow where people of my age are starting families. The only shock I had was at my friends and how easily they fell away and how society and the family unit could be so exclusive. The full impact of society's expectations came crashing upon me and that was quite shocking... I was excluded .. from cosy family life .. and I didn't expect that ..* Sophie

Similarly, Harper found herself excluded from societal norms albeit in a different way from Sophie. Prior to his death, Harper had separated from her husband due to his increasing substance abuse and had filed for divorce. Unable to admit either to herself or to anyone else the reality of her abusive marriage - '*I didn't want to break that bubble for myself let alone admit it to anyone else*' - Harper was also unable to disclose the details of her husband's death. Harper's incongruent self-concept was possibly exacerbated by the socially-stigmatised circumstances of her husband's death and could therefore have resulted in her isolation from sources of support.

It's because it was so complex, the relationship from when he died, and prior to that, and also that stigma I was left with and it was not fitting with me, and how could I say my husband died because he took a heroin overdose? – that doesn't fit. Harper

She therefore suppressed her feelings, maintained a familiar pattern of coping 'on my own' and focused entirely upon her children's needs.

*Because I was at that point still burying the children's father so they were the chief mourners, it was whatever **they** needed .. I don't think there was any linking it to how is this for me ..*

A significant concomitant loss for Harper was the loss of the 'innocence' in her Christian faith resulting in what she termed 'a more useful faith'. The death of her husband had presented a powerful challenge to her assumption that God would 'sort things out', (in her marriage) and nothing could have prepared her for the eventual outcome.

*(Quietly) And I guess my belief system is that it **was** sorted. It wasn't quite the way that I wanted it..*

For Goldie, losing her mother had prompted her to reflect upon both personal and existential issues.

It makes me more acutely aware of my own mortality and the mortality of others and those around me .. it's made me much more aware of the passing of time .. and how we all get older.

In terms of her sense of self Goldie reported that although she still felt the same person, she was aware of the societal label that could now be attached to her.

*I still feel the same person I was .. (Matter-of-factly) Okay. I'm an orphan now ... so that gives me another **label**.*

Sophie experienced a significant and positive change to her sense of self and worldview following her husband's death, describing it as being '*released from pettiness*' and '*liberated*' from her fears.

*(Animatedly) As soon as ---- died I got this **massive** sense of compassion ... My whole feeling inside is so different. I used to be a very angry person... quite bitter and cynical ...and looking at the world through dark-tinted glasses ... By being shown the worst it could get, I was liberated from a lot of fears .. If I can do this then I can do anything and that was **really**, really liberating.*

Conversely, Jessica's whole sense of internal agency, linked to her instinctive maternal desire to save her child, had been destroyed not only by the circumstances surrounding the death of her daughter, but also by the subsequent discovery that her organs had been used in the organ retention scandal. For Jessica, her sense of utter powerlessness and disbelief resulted in a '*huge distrust of the NHS and medical institutions*' and intense feelings of violation, injustice and exposure. Jessica's assumptive world had been seriously disrupted and she experienced difficulty in making any sense of her experience at the time of this medical outrage.

*I felt like a **specimen** .. it happened to **her**, it's not just out there, and I really did feel that that there was public interest in my private torment which I guess like this goldfish bowl where everyone's looking in and it felt beyond words, it **still** feels beyond words that a medical institution, of all places, could steal parts from a defenceless dead child, and I was **completely** in bits. ... That **can't** be made sense of really, you know.*

Master Theme 2: Re-learning the world

Sub-themes:

- **Personal growth and the reconstruction of self**
- **Being heard and witnessed**

A major theme to emerge from the study was the way in which loss can act as a catalyst for personal growth and development. Aspects of personal growth included discovering new strengths, increased self-awareness and confidence, and greater self-esteem. Participants were better able to connect with others and to establish new relationships. It was clear that all participants had drawn upon previously undiscovered inner resources of resilience and strength as a direct result of the bereavement experience. These changes however, evolved over a period of time.

Sub-theme (i): Personal growth and the reconstruction of self

The participants reflected upon their journeys towards growth and a reconstructed self in rich, figurative language that conveyed the dynamic changes in their self-concept and in their relationship to the bereavement experience.

*(Reflectively) I'm freed from the **chains** of the bereavement as a very **negative** and very **damaging** experience ... I'd have loved him **not** to, but I don't know who I would be .. I've changed so much and like lots of the changes. It's **so** moulded who I am .. a juxtaposition really, how can something so **negative** make such a positive. Harper*

Jessica too used a beautiful metaphor to describe her own growth and healing.

*But through my experience of losing my child and the process of recovery, I have grown both personally and spiritually, which is for **me**, the gift that comes out of the wreckage of pain.*

Jessica further described how through the process of writing her book, she came to the realisation that she had 'survived'.

Sophie reflected upon the strengths she had gained and her increase in self-esteem. Moreover, whilst accepting her socially-defined status as a 'widow', she perceives her personal identity as separate from this.

From what I was before I am an entirely different person inside and out. I prefer the person I am now ... I found a great strength which doesn't feel like hard strength, it feels like a very soft strength.

It was something that happened. It's a circumstance. Yes, I'm a widow but it's not who I am. Sophie

Sub-theme (ii): Being heard and witnessed

'Being heard' constituted an issue of major importance for all participants, but was demonstrated in differing ways. Despite the positive changes in her life, Sophie for example, had become aware of feeling 'unwitnessed', and reflected upon how this had changed when she recently entered a new relationship.

*I have a feeling of my life .. because it's being witnessed, it's got less fragmented. It's almost in the **telling** of my life it's got a thread to it .. And so I feel more knitted together than I have for the last five years.*

For Jessica, the huge contrast between *not* being heard – and the devastating consequences that followed – and later being *fully* heard and acknowledged was central to her process of *re*-connection and *re*-engagement in the world. Similarly, Harper's experience of being heard and accepted represented a significant turning point, marking her '*conscious decision*' to grieve.

*And she chatted on as this equal which was a bit mind-blowing really. **Really, really** blew me away that these people would accept me for who I was. Harper*

Goldie's desire to be heard was her motivation for taking part in this study, as illustrated by the following extract:

*I felt this would help me too.. bring about some type of **small** catharsis ... that it's a legitimate way of feeling.*

Master Theme 3: Personal and professional synergies

Sub-themes:

- ***Integration of personal and professional reflection and development***
- ***The validating role of supervision***

This master theme relates specifically to the second part of the research study in that it acts as a 'bridge' between the personal and professional lives of the bereaved therapist-participants. It also constitutes a precursor to the final master theme and therefore the two are closely interlinked.

Sub-theme (i): Integration of personal and professional reflection and development

All four participants demonstrated that continued personal and professional development was essential for safe and ethical practice, and participants were honest about the professional challenges they faced in training and when working with clients.

*For me, self-knowledge, self-awareness is **really** really important, it's what's kept me sane this far and what (quietly) keeps my practice safe.*

Harper

Participants also commented on the importance of having faced and worked through their own losses, a point Jessica illustrates in the following passage.

My belief is that we need to have some personal experience of the process of touching and working through some of our own painful or shadow places because that's what clients bring to us ..

All the participants engaged in continuing reflection upon their practice and were aware of when their own needs might possibly impact on their client work. Sophie for

example, described the incongruence she had felt between her personal and professional lives prior to meeting her new partner.

I see myself as witness to somebody's experience ..it's a big part of how I think about it, and yet I'm feeling unwitnessed .. I felt uncomfortable and wondered if I was being as effective as I could be or if I was in danger of having my needs met.

Goldie's expressed a different view and described her belief that:

*...as therapists we sometimes attract the clients that provide something we either have to work through ourselves or something that we are able to help others with... And then ... **especially** strangely enough within the last few **months**, getting a number of people coming with bereavement issues. And I believe it's because we can help each other in a way.*

Sub-theme (ii): The validating role of supervision

Central to the participants' personal and professional development was the validating and professionally-enhancing role of supervision. All the participants described having a safe, trusting, open and honest relationship with their supervisors in which they were validated both personally and professionally. In all cases, the participants had been able to discuss their bereavements with their supervisors and the possible implications for their client work.

I have been able to feel very comfortable in talking to her about how it's related to my practice as well as speak to her on a personal level.
Goldie

Sophie reported how her supervisor was:

... very good at getting that this is how I am and therefore everything that I say, or report, or process at the moment is being processed through this filter of how I'm feeling ... but then he brings it back to

clients ... and that's been really useful... I guess that thing of being heard actually.

Similarly, Jessica reported how, through supportive supervision, she had been able to address her personal issues of powerlessness and not being heard.

I came up with the concept of a 'pause button' and that was to separate and prevent triggers from my earlier trauma from becoming entangled and interfering with the present ... so I could engage more effectively with my clients.

Master Theme 4: Impact on therapeutic practice

Sub-themes:

- ***Personal experience enhances empathic understanding and connectedness in the therapeutic relationship***
- ***The issue of self-disclosure***

Sub-theme (i): Personal experience enhances empathic understanding and connectedness in the therapeutic relationship

It is clear from the findings that the participants' experiences of bereavement have had a considerable impact upon their therapeutic practice. What is also clear is that the quality of this impact continues to change over *time* as a result of the participants' personal growth and professional development.

*I can empathise with them because I **have** experienced, am experiencing, what they're feeling... an unseen energy can go between us.*

*Knowing that my client **feels** that they are able to comfortably communicate with me and that they feel a certain rapport with me .. that my client feels I'm understanding them .. and focused on **them** and their situation ... It's mutual. Goldie*

Jessica's ability to connect deeply with her clients mirrors her own internal re-connection to the world, to herself and to her daughter, and her continued integration of personal and professional learning.

The most important part is that my experience gives me personal understanding and insight of emotional pain and the process of recovery. I have experienced that, come out the other end, so that is a great benefit to clients who are on their journeys through their own pain.

*(Slowly and reflectively) It's generated in me a sense of humility and awe and also a belief that people can in a healing environment come through pain and trauma... I'm aware, like the client, that I'm not immune from experiencing pain and uncertainty, and it's a part of what makes us both human, so that is another connecting... I think there is a (pause) maybe like a **soul** connection. Jessica*

Sophie described having a 'neutrality' and 'easiness' with bereavement issues and had no fear of discussing them. She could 'tune in' to the 'darker side' of her clients' feelings because she had experienced similar feelings. What was most significant for Sophie was her recognition of how her practice had changed following her new relationship in which she felt her need to be 'witnessed' was being met. This seemed to highlight, on reflection, what had perhaps been missing in her practice - and her 'self' - previously.

*What I've noticed is a much freer sense ... a definite **relaxing** of my being. I don't need to worry about what am I offering or not offering. I'm just going to be here and be available because actually my needs are being met ... I come out of sessions **often** now and think WOW, that was a **really** good session ... whereas before I'd feel that was okay ... it's gone from everyday okayness to kind of transformative, the creativity's gone back into it for me. I am being a **fresher** witness ... not a stale witness.*

Harper described how her continuing personal growth related directly to what she was able to bring to her counselling work, and acknowledged the importance of having connected with her own emotions in a gradual process of 'maturing' and insight as these extracts exemplify.

(Slowly and reflectively) I guess it feels like a maturing ... I always start with and naturally go to a very heady place, and it's seeped down to a more feeling place, so I'll be able to use it as a much more feeling place...

As one of her clients finally begins to grieve, Harper described her response as a counsellor:

*And it's not coming from **head** knowledge, it's I've been there and that sense that we communicate, it seems to be not just verbal communication .. it's just unsaid .. and just being there with her.*

In terms of the therapeutic relationship Harper reported a comment one of her clients had made on the '*parallelness of our experiences*' and explained this further:

*It's how I feel about **how I work** .. well, we connect on some of those areas that are very **similar** and the relationship is connecting round there and I'm able to offer her a lot more of **that** part of me and **connect** with that part which in **our** relationship is how it works ..*
Harper

Sub-theme (ii): The issue of self-disclosure

All participants demonstrated a considered and ethical approach to this somewhat controversial issue and made it clear that any disclosures made were solely for the client's benefit. Three of the participants reported using self-disclosure as a therapeutic intervention when working with bereaved clients. Conversely, Sophie reported that she had not yet felt that it was '*in the service of the client*' to self-disclose, although she remained open to the possibility.

*(Slowly) I feel that it can be very, very useful but it has to be appropriate counsellor disclosure... I think it's particularly facilitative when clients have **strong** feelings, strong emotions ... in my experience clients who*

*have lost a child have appreciated and benefited from my disclosure because they **know** that I've also experienced and **really** understand the personal impact of such a loss...that she **really** does get that ...*
Jessica

*I would never impose my feelings on a client ... but I can empathise with them not sympathise because I **have** experienced or I'm experiencing what they're feeling ... I can give them just that little piece to show them that I understand and I **care** about them .. but this is **their** session, not **my** session.* Goldie

Harper described feeling 'untruthful' by not self-disclosing to a client whose material bore remarkable parallels to Harper's own experience. After discussing the issue in supervision Harper made the decision to self-disclose a little of her own experience and was congruent in revealing her in-the-moment feelings.

*And so we explored it a lot ... I felt I was holding something back .. I was being untruthful even though it wasn't about being untruthful .. I was just holding back such a big part of me ... And just trusting her and wanting to offer that to her ... that we could maintain .. that it wouldn't suddenly become something that wasn't therapeutic. But in that relationship it's (pause) it's been **crucial** for me and for how we work together.*

Participants also reported how judicious self-disclosure helped to equalise the power imbalance in the relationship and helped clients to realise that therapists are not immune from personal pain, and that we all share a common humanity.

CHAPTER FIVE: DISCUSSION

In our own woundedness we can become a source of life for others.

Henri Nouwen

When the therapist faces a life-changing event in her own life, her professional life is also irrevocably altered. The loss through death of a loved one is such an event. The aim of this phenomenological research study was to explore the lived experiences of four humanistic therapists who had experienced a significant bereavement and its impact upon their therapeutic practice. Four main themes comprising eight sub-themes emerged from the analysis of the data which seemed to best capture the 'essence' of the participants' experiences. These were contextualised within an over-arching temporal framework in order to capture the nature of grief as an evolving process, and to mirror the continuing changes in both personal and professional development (Skovholt & Ronnestad 1995). This chapter offers an integration and synthesis of the findings in relation to the extant literature.

There is a general consensus of opinion that whilst bereavement is a universal experience, it is also unique to the individual. Indeed, the death of a loved one "invalidates assumptions that penetrate many aspects of life" (Parkes 2000 p. 327) and shatters our existing schema of the world as well as our meaning-making systems (Attig 2001; Matthews & Marwit 2006; Neimeyer 2005). The experience of bereavement can result in psychological, physiological, cognitive, emotional and spiritual responses that can impinge on all aspects of everyday life (Parkes 2000). It can also evoke existential questions and the confronting of the "limits of ordinary meaning and of facing existential meaninglessness" (Landsman 2002, p.20). Moreover, unlike the death event itself which can occur in an instant, the subsequent process of

grieving cannot be so easily measured and is different for everyone (Worden 2010). The uniqueness of the event is also determined by factors such as the circumstances of the death, the bereaved individual's relationship to the deceased, individual personality and social support network (Field 2006a; Lendrum & Syme 2004; Neimeyer 2001, 2005; Rando 1993; Worden 2010).

It is clear from the findings that the individual journeys through grief of the participants in this study were characterised by the specific circumstances surrounding and leading up to the bereavement which partly determined their initial and subsequent responses to the event (Worden 2010). In some respects, three of the four participants had experienced bereavements that were 'off time', and thus inconsistent with life-stage expectations, whereas the fourth participant's bereavement was in the 'natural order of things'. For each participant, the bereavement constituted an event that challenged her previously held assumptions and world view giving rise to an incongruence between the world as it 'is' and the world as it 'should' be (Matthews & Marwit 2006; Parkes 2000). This was consistent with the experiences of several of the therapists cited in the literature review (Chalmers 2009; Chasen 1996; Callahan & Dittloff 2007; Felberbaum 2010; Ryan 2007.)

The participants reported a range of affective responses to their bereavements that attested to the force of the emotional impact of the experience, often conveying their feelings through the use of vivid language and metaphor. Their accounts echo those given by the bereaved therapists (Browning 2003; Dittloff 2007; Lambert 2003; Mendelsohn 1996; Weingarten 2010) and those of the participants in Millon's (1998) study. However, there were individual difference in the ways participants responded to the initial impact of the death and their subsequent ways of coping. Jessica for

example, described feeling '*absolutely stunned*' and '*catapulted to another realm*', by her daughter's death and the circumstances surrounding it, and was overcome by intense feelings of powerlessness, feelings that she later suppressed because it was '*too harrowing*' to face. Harper's initial reaction was one of '*mixed feelings*' including relief from fear of abuse. Sophie reported having '*no memory at all*' of the actual event, together with a paradoxical '*liberation from a lot of fears*'. Goldie had experienced anticipatory grief followed by deep sadness and regret when the bereavement finally occurred.

Another theme to emerge was the effect the bereavement had upon the participants' internal sense of self and social identity. Research has suggested that one of the main challenges (Holland, Currier & Neimeyer 2006; Neimeyer 2001, 2005) of the evolving process of grieving is for the bereaved to make sense of the loss and "construct a new modified identity – one that incorporates the loss and the overwhelming feelings of grief that bereavement brings with it" (Matthews & Marwit 2006, p.91). From a social constructionist perspective (Gillies & Neimeyer 2006; Paletti 2008) bereavement is seen as embedded within a social context encompassing socio-cultural, traditional, religious, ethnic, familial and communal values, beliefs and expectations. However, for some of the participants in this study, their exclusion from these 'societal norms' resulted in a disintegration of a social identity that took time to rebuild. This impacted upon the grieving process for Sophie and Harper especially. For example, Sophie vividly described how, following the death of her husband, she was given the '*cold shoulder*' and excluded from her peer friendship group because she no longer '*fitted in*' to a '*cosy family unit*'. Unable to bear the rejection, she relocated and endeavoured to begin a new life. A point of conjecture is that the move away exacerbated Sophie's sense of the death event being '*frozen*', and prevented her from being able to establish a continuing bond with

her husband through talking about him to others who had known him (Field 2006b; Klass, Silverman & Nickman 1996). Clearly, she was denied the social support so necessary for the recently bereaved (Attig 2004; Doka 1999). Harper, on the other hand, felt she was left with a '*stigma*' resulting not only from the fact that her husband had died from a heroin overdose, a type of death not socially sanctioned (Attig 2004; Doka 1999, 2002), but also because she was unable to admit to herself that her marriage had been abusive: '*It didn't fit with who I was*'. Thus she suppressed her feelings, maintained a familiar 'coping' strategy that was cognitively oriented and focused on her parental responsibilities at the expense of addressing her own grief.

The experiences of Sophie and Harper would seem to be consistent with the work on disenfranchised grief (Attig 2004; Doka 1999, 2002) in that both, albeit in different ways, were deprived of the support and "empathy for their longing to overcome suffering, grow through their experiences and live meaningfully again" (Attig 2004, p209). Their experiences are shared to a different degree by Jessica whose expectation that she could trust the socially constructed cornerstone of the NHS was cruelly destroyed, firstly when her baby daughter died, and secondly, in the re-traumatisation of discovering that her daughter's body had been '*violated*' and her organs used in the organ retention scandal. Jessica experienced a violation of her *own* world at that point which re-opened the painful wounds inflicted by the original circumstances of her daughter's death and her ensuing feelings of powerlessness. The participants' experiences echo the pain and loss of several of the bereaved therapists as they too struggled to adjust to a dramatically changed world (Callahan & Dittloff 2007; Chasen 1996; Felberbaum 2010; Lambert 2003; Morrison 1996; Ryan 2007). In contrast, despite feeling that she had not properly said 'goodbye' to her mother, whom she was missing intensely both as a parent and a confidante,

Goldie was able to grieve more openly, and did not feel that her social identity had changed as a result of her mother's death other than her recognition that she had become an '*orphan*'.

A significant theme to emerge from the study was the way in which loss can act as a catalyst for personal growth and transformation and can thus, in part, transcend the experience of bereavement. Indeed, the theme of triumphing over adversity has acquired mythological status, crossing the divide of historical and cultural contexts. (Paletti 2008). The continuing process of personal growth is also supported by humanistic thinkers, including Rogers (1961). For the participants in the study, the process of 're-learning the world' was a gradual one that included '*working through*' different aspects of the bereavement experience. The participants' experience of personal growth is consistent with research in this area that identifies certain characteristic features of growth that include not only a changed sense of self, changed relationships, and a changed philosophy of life, but also existential and spiritual growth (Bonnano 2004; Calhoun & Tedeschi 2001; Davis 2001; Schaefer & Moos 2001). Additionally, the participants reported the discovery of new strengths, increased self-awareness, greater confidence and self-esteem, maturity, compassion, and the ability to reflect upon their experience of bereavement from a more comfortable place.

Whilst personal therapy had played an important part in the process of readjustment for two participants (Macran, Stiles & Smith 1999), it was evident that all participants had drawn upon previously undiscovered inner resources of resilience and strength as a direct result of their bereavement experience. The participants' experiences of personal growth correspond with the findings in Givelber & Simon (1981), Millon (1998) and Bozenski (2006), and with several therapist reflections (Browning 2003;

Chalmers 2009; Gerson 1996; Lambert 2003; Small 2000). It is important to note however, that positive outcomes emerge slowly “as the dawn of healing replaces the lonely darkness of grief” (Frantz, Farrell & Trolley 2001, p.192), and that the presence of growth does not mean an absence of pain. Paradoxically, there can also be increased feelings of vulnerability connected to a greater sense of the fragility of life. Tragedy and loss therefore should not be seen as a necessary pre-requisite for personal transformation, and not every individual will engage in this ‘growthful’ process to the same degree (Calhoun & Tedeschi 2001; Davis 2001).

It is not surprising, given the disempowering experiences of most of the participants that ‘being heard’ constituted an important theme in this study. Also of note is the link with person-centred therapy which is characterised by the therapist’s active, attentive and empathic listening as she endeavours to understand the client’s phenomenal world (Mearns & Thorne 2007). Attig (2004, p.212) suggests that in terms of disenfranchised grief, being affirmed, validated, and heard by “active listeners” is essential in legitimising the mourner’s experience, and the participants emphasised the importance of this in facilitating their grieving process. Jessica reported the ‘*huge contrast*’ between ‘*not being heard*’ and then being ‘*fully heard*’, and Harper described her experience of being listened to and accepted as ‘*mind-blowing*’. For Sophie, the experience of feeling ‘witnessed’ in a new relationship had an ‘*immediate effect*’ upon her sense of well-being and on her practice. This desire to be ‘heard’ accords with Neimeyer’s (2001) belief that in order to make sense of the loss, the bereaved need opportunities to tell and retell their stories, as meaning-making is central to the bereaved individual’s attempt to accommodate the loss and to “re-organize one’s identity as survivor” (Neimeyer, Baldwin & Gillies 2006, p.71).

The interface between the personal and the professional was another major finding in this study. All participants described their commitment to personal and professional exploration and development. They reported an openness to working through difficult personal issues in a continuing process of honest and questioning self-reflection. Two participants emphasised the value of personal therapy in helping them to overcome the early rawness of grief, and both attested to the therapeutic insights gained from their experience of being a client (Macran, Stiles & Smith 1999; Rake & Paley 2009). For example, following the devastating discovery that her daughter's organs had been used for organ donation, Jessica's experience of inhabiting the '*fertile void*' - a place of turmoil and stuckness - enhanced her ability to recognise this in clients. Similarly, Harper described how, through her experience of facing her '*brick wall*', followed by a process of working through her grief, she moved from a '*heady place*' to a '*much more feeling place*' that now informs her therapeutic work in a meaningful way. This interrelationship of the personal and professional is consistent with the body of research on the evolving professional self (Orlinsky & Ronnestad 2005; Ronnestad & Skovholt 2001, 2003) which suggests that the therapist's personal life is a central component of professional functioning in that "profound events in one's life ... provide intensely important information for the individual in terms of his/her counselling/therapy work" (Skovholt & Ronnestad 1995, p.79). An important point to consider however, is that the participants were at different stages in their professional careers *as well as in their grieving process*, and therefore individual challenges were reported.

A key element in this theme was the role of supervision. All participants reported being in supervisory relationships in which they were listened to and affirmed in a holistic sense, and in which participants felt safe to expose their vulnerabilities and explore implications for client work (Henderson 2005; Page & Wosket 2001). This

was an interesting finding and contrasted with the therapist accounts and with previous research studies (Millon 1998) in which scant reference is made to supervision. This would appear to be a significant omission particularly as Orlinsky & Ronnestad's (2005) research identifies supervision as one of a major triad of positive influences on professional development. Although supervision and personal therapy can be viewed by some as different processes, Tudor & Worrall (2007, p.171) see this distinction as both 'restrictive' and 'reductive', commenting that "We have both heard ... too many practitioners describe feeling unheard, unhelped and unsupported" (ibid, pp.170-171) when supervisors decide that the (perceived) boundary between the personal and the professional is in danger of being breached. Certainly the experiences of the participants corresponds to Tudor & Worrall's (2007, p.170) assertion that the 'professional is personal'. Moreover, in terms of the importance to the participants of 'being heard', supervision played a significant role in validating and legitimising the interrelationship between the personal and the professional (Orlinsky & Ronnestad 2005), thus facilitating an integration of a focus on the phenomenological experiences of clients with the therapist's "reflective awareness of the meaning and impact of suffering and loss in his/her own life" (Browning 2001, p.325).

The fourth major theme concerned the impact of the participants' bereavement experiences on their professional practice. Research suggests that, irrespective of theoretical modality, it is the quality of the therapeutic relationship that is linked to positive outcome for clients receiving counselling and psychotherapy (Beutler & Machado 1994; Cooper 2008; Mearns & Cooper 2005), although as Reupert (2008, p.372) suggests: "It has proved difficult to isolate a specific therapist characteristic or personality that is directly associated with positive or negative therapeutic outcome". All four participants in this study reported that the creation of a healing therapeutic

relationship was the most important aspect of their professional practice, a relationship characterised by - in the participants' words - '*genuineness*', '*empathy*', '*rappport*', '*trust*', '*mutuality*' and '*connectedness*'. Bearing in mind the significance of time and the importance of having worked through their own personal grief (Hayes et al 2007), the participants reported that their experience had impacted upon their practice in mostly positive ways. When engaged in therapeutic work with clients, the participants reported experiencing increased levels of connectedness and attunement, deepened empathic understanding, compassion, and an enhanced ability to '*be with*' and '*hold*' clients in their pain (Bula 2000). There was also an increased awareness of spirituality and the existential aspects of life and death, together with an acknowledgement of the randomness of life events (Callahan & Dittloff). Participants emphasised the importance of being 'real' and 'authentic' and of bringing the 'whole self' to the relationship (Baldwin 2000; Shadley 2000; Rowan & Jacobs 2002). There was a profound sense that having personally experienced a traumatic and painful event in their own lives – *and having come through it* – added considerably to the depth of the participants' connection with clients, a connection that did not always require verbal expression.

The experiences of the participants share commonalities with the experiences of the bereaved therapists (Browning 2003; Bula 2000; Chalmers 2009; Lambert 2003; Menos 2004; Small 2000; Walsh 2004) and are consistent with the findings from Millon's (1998) and Bozenski's (2006) studies. The participants in these studies also reported a heightened sense of empathy with clients and an ability to respond to clients with greater sensitivity (Dunphy & Schniering 2009; Givelber & Simon 1981). Furthermore, the findings from this study are consistent with recent research on empathy by Greenberg & Rushanski-Rosenberg (2002) and Geller & Greenberg (2002) which discuss the role of 'presence' in the therapeutic relationship (Rogers

2000). The participants' accounts of their experiences with clients include several references to a 'way of being' (Rogers 1980) that has at its core a deep sense of connectedness and the recognition of a common humanity; a recognition described below by Jessica.

...we're all unique but we're also connected in as sort of fellow travellers in life, we're each on our own personal and spiritual journeys...

The ineffability of the therapeutic encounter was also described by the participants, albeit in different ways and resonates strongly with recent person-centred research on 'relational depth' (Cooper 2005; Mearns & Cooper 2005). Certainly the participants in this study had all shared moments of what could be described as relational depth, those "poetic moments" (Browning 2003, p.334) characterised by a quality of relating that was often unspoken. Sophie described her experience as follows:

It feels like the two or three of us are walking the same path for that moment and at those times I perceive that I get their world as they see it... a kind of expansion of my world ... then there's a kind of trust that opens up and a willingness to be as open as possible to experience.

An important element of this final theme was the issue of self-disclosure, an issue of some contention and debate in the literature. The findings from this study however, appear consistent in some areas with the views expressed by the bereaved therapists, particularly in regard to the positive benefits that can ensue from ethical and judicious self-disclosure. In the accounts of several of the bereaved therapists however, most of whom were psychoanalytic in orientation, self-disclosure was regarded as both a threat to the transference (Chasen 1996) and, in some cases, a self-protecting strategy (Vamos 1993), particularly in the early phases of grief.

However, other considerations related to not wishing to burden clients or inhibit them from addressing their own issues (Morrison 1996; Givelber & Simon 1981). Conversely, Mendolsohn (1996, p.24) found that when he disclosed openly to clients, he felt “closer and more involved”. Millon (1998) however, found that even when participants did *not* disclose, their clients nevertheless noticed subtle changes in the therapist’s demeanour and attitude. Some therapists found that self-disclosure enhanced the therapeutic relationship, increasing trust and resulting in a more egalitarian relationship.

For the participants in this study, there were fewer anxieties in terms of whether or not to disclose, due perhaps to the participants’ humanistic orientation which is more supportive of self-disclosure (Rowan & Jacobs 2002). Rather, the issues concerned the appropriacy of self-disclosure within the context of a specific therapeutic relationship. In the present study, self-disclosure was used solely for the benefit of the client as a therapeutic intervention aimed at conveying empathic understanding and deepening an already-existing connection (Shadley 2000). Such disclosures were made with due regard to ethical considerations and had often been discussed in supervision. For example, Jessica reported that when working with clients who had lost a child she would, if appropriate, briefly disclose her own experience as a way of enabling clients to articulate the un-articulable, and as a way of assuring them that *‘I really do get that’*. When the client’s material paralleled the participant’s experience, self-disclosure was perceived as being particularly helpful. This is consistent with Knox’s (2007, p.318) research in which she found that therapists are increasingly emphasising the cautious use of self-disclosure in “helping clients to achieve a deeper level of revealing themselves”. In terms of the impact on practice, self-disclosure was viewed by most of the participants as enhancing the therapeutic

relationship and contributing to a positive outcome. Furthermore, in this study it was seen to contribute to moments of deeper connectedness and communication.

CHAPTER SIX: CONCLUSION

The aim of this qualitative research study was to explore the impact on practice of four humanistic therapists who had experienced a significant personal bereavement. Previous studies have researched the experiences of psychodynamic practitioners (Millon 1998), and thus this study makes an additional contribution to the existing literature in terms of the theoretical orientation of its participants. The choice of a phenomenological design and methodology was highly appropriate for this in-depth study of the lived experiences of the participants. The selection of IPA as an inductive, iterative method of data analysis was also appropriate in enabling me to gain a deep insight into the participants' experiences. These were subsequently interpreted through a combination of a hermeneutics of empathy and of questioning (Smith et al 2009).

The findings from this study suggest that the participants' experiences of bereavement and the process of grieving are generally consistent with the major themes in thanatological thinking. All participants reported an evolving process of 'working through' their grief (Rando 1993; Worden 2010) and most described their attempts to make sense of their loss (Neimeyer 2001) as part of re-learning their assumptive world (Attig 2011). Reference was also made to maintaining a continuing bond with the deceased (Klass 1996) and a changing relationship to the bereavement itself. The significance of time was a major factor in this process. The experiences of some of the participants were consistent with Doka's (2002) work on disenfranchised grief and this linked to the embeddedness of bereavement within a social context, subject to existing societal norms and discourses. All participants reported individualised experiences of personal growth and an increased sense of

personal autonomy that corresponds with research by Calhoun & Tedeschi (2001) and Davis (2001).

It is clear from the findings that the fabric of the personal and professional lives of the therapist-participants who contributed to this study are interwoven, and this is exemplified in the themes discussed above. Also clear is the professional imperative to work through personal issues in a continuing process of reflective self-development (Ronnestad & Skovholt 2001; Skovholt & Ronnestad 1995). Central to this development is supervision. This finding did not correlate with the findings of previous studies (Millon 1998), or with the accounts of the bereaved therapists, in which supervision received little attention.

With regard to their therapeutic practice, the participants reported that there had been a positive impact including a heightened degree of empathy and connection with clients. However, the positive impact was related to their own personal journey through grief, and also to their continuing professional development. Participants spoke of how the impact on practice changed alongside their changing relationship with the bereavement. This finding is consistent with Hayes et al's (2007) research which found a correlation between the length of time since the therapist's bereavement and the level of empathy offered to clients. An interesting finding was the use of self-disclosure by three participants to enhance client trust and disclosure, a finding that concurs with Knox's (2007) research. There was a consensus of opinion however, that self-disclosure must always be in the best interests of the client.

Whilst the study has illuminated further the area of therapist bereavement, there are limitations that must be noted. Firstly, although the sample size was appropriate for an interpretative phenomenological analysis, it was not balanced in terms of gender,

ethnicity or social class. Moreover, participants were self-selecting. Secondly, no criterion was stated regarding type or circumstance of death. The bereavement experiences of three of the participants could be described as 'traumatic' to some extent and this could not have been predicted. It is difficult therefore to generalise from the experiences reported here. A third limitation was the level of selectivity that was necessary for a dissertation of this size. The data produced were extensive and 'rich' in content and inevitably some of this richness has been lost. Each participant's experience could easily have produced a case study in its own right. Fourthly, the research was inevitably influenced by my own personal and professional experience, and whilst IPA acknowledges the subjective role of the researcher, it is important to note that another researcher might have foregrounded different aspects of the data.

This qualitative study has, I hope, filled a gap in the literature by exploring the experiences of four humanistic therapists who have experienced significant bereavement, and its impact on their professional practice. However, further research might consider the following areas:

- A longitudinal qualitative study to explore the changing impact on practice alongside the therapist's evolving grieving process. This would involve interviewing bereaved therapists at different stages of their personal and professional lives and would augment Hayes et al's (2007) quantitative study.
- A study of bereaved therapists' experiences of supervision.
- A comparative study of male therapists' experiences of bereavement and its impact on practice.
- A study into the ways in which trainees' bereavement experiences are addressed in training outside of personal therapy.

- A comparative study into bereaved therapists' and non-bereaved therapists' experience of relational depth.
- A study exploring the experiences of bereaved therapists working specifically with bereaved clients.

This study has endeavoured to give a voice to the therapists who contributed to this research project. My hope is that their voices have been heard. It is clear from the findings that in order to draw upon the 'touchstones' of their own vulnerabilities in the service of their clients, therapists need to have arrived at a place in their own healing process that enables them to facilitate an empathic therapeutic relationship with clients whose own material may mirror the therapist's. It is however, the *lived experience* of this process and the knowledge that wounds, although never forgotten, *can* be healed, that therapists bring to their therapeutic practice. For the participants in this study, their struggle to heal their own woundedness is inextricably linked to their desire to bear witness to another's pain, and to bring their whole 'self' into the therapy room. It is in that particular space where the personal, the professional and the human meet in the service of healing.

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APPENDICES

APPENDIX 1

Epilogue and reflection

I wrote in my Reflective Research Journal that I was avoiding beginning the analysis because I felt daunted by the length of the transcripts and the challenge of the task facing me. As I write this I am aware of feeling a similar disinclination to ending what has been such a major part of my waking - and sleeping - hours for some months! I could never have envisaged that my own personal and professional journey would lead me to this point in time as I sit and write this epilogue and reflection. Looking back to the beginning of the MA programme, I think I was always clear what I would do for my research project. Having lost a number of significant people through bereavement, and having only worked through the most painful and disenfranchised of these bereavements during my counsellor training, I wanted to explore the experiences of other bereaved counsellors. I know that my own experiences of bereavement - and of coming through it - act as a 'touchstone' for my practice with bereaved clients in a hospice setting, and therefore a research project in this area seemed a possibility. I was clear however, that I did not wish to do an heuristic study and so a phenomenological approach seemed the most appropriate. What a challenge ...

Determined to understand the philosophy underpinning IPA, I wrestled with the differences between Husserl and Heidegger, and tried to develop a familiarity with hermeneutics – both double and circular! Thank you to John McLeod and Jonathan Smith for making much of this accessible. The next step was to recruit my

participants and I felt both excited and apprehensive when four respondents met my inclusion criteria and the interviews were arranged. My perception of my role as researcher was quite clear at that point: professional, but with an acknowledged 'insider' perspective. The interviews themselves involved a fair degree of travel and were conducted fairly close together in terms of time. This proved difficult as I was not as prepared as I had imagined for the cumulative effect of hearing four very distressing stories in such a short space of time, coupled with my on-going counselling work. However, like the participants in this study I am fortunate to have an excellent supervisor who provided good support, together with my research supervisor. One thing I had not anticipated was how moved I would feel by what I heard. It was difficult therefore to maintain an entirely detached role. Looking back, I feel that the rapport I created with the participants and the empathy I showed helped to produce the rich data that were collected. This is an important point and one that needs to be made clear to anyone researching a sensitive area.

The analysis of the data was again quite challenging, particularly the transcribing which was very time-consuming. Nonetheless, IPA provided an excellent method for analysing the data and for some weeks I was completely immersed in the participants' stories. During this time, they ceased to become 'the' participants and I found myself referring to 'my' participants. Although I could not have predicted what experiences they would recount, there were some parallels between our experiences. One of the biggest challenges therefore was to 'bracket off' my own preconceptions and biases and endeavour to remain open to what was being revealed before me. This was a constant dilemma for me as the researcher as it is so difficult to *not* know what you know! I did however, manage this quite well and

used similar techniques to the ones I use in counselling in order to remain in the client's frame of reference.

Carrying out this research study has been, for me, an experience of growth, both personally, professionally and academically. It has provided the opportunity to challenge myself – particularly with regard to the reading and the analysis – and has consolidated the learning I have acquired during the MA course. Listening to the participants' experiences has prompted me to re-evaluate my own bereavements and how my relationship with them changes over time. I share the participants' wishes that their bereavements had not occurred, but I can also, as they did, reflect back on the positive changes in my life that might not have arisen had I not had that experience. No-one knows, of course, what 'might have been', but must live with 'what is'. Like the participants, I share a strong commitment to bearing witness to other people's grief as this in some small way, enables me to give to others what I never received myself until many years after the event. For all of us, it is what gives our work meaning.

Finally, whatever one does, whatever interactions one has, one is ultimately changed by them. I have been changed by this research; by the four participants who chose to take part; by their stories; by their bravery. It has been a privilege to be allowed to enter a very private place in another's life, and I thank them. I hope this study does justice to their bravery.

4.12.11

APPENDIX 2

Table 1 Indicative search terms related to area of research

Impact on therapeutic practice	Person-centred/ humanistic therapist	Personal experience of bereavement	Qualitative research: phenomenology
OR "influence on" OR "effect on" OR "impact on" AND "therap* practice OR "clinical practice" OR therapeutic relationship"	OR therap* OR counsel* OR person cent* or client cent* OR humanis* AND therap*	OR grief OR "significant loss" OR "own experiences" AND loss OR "personal experiences" AND grieving OR "personal stories/narratives"	phenomenol* AND research phenomenol* AND bereave* OR grief
"person-cent* AND empathy AND couns* "relational depth" OR connectedness AND counsel* "use of self" AND person-cent* AND empath*	"Person-cent* therap*" AND supervision Counsel* AND "self- disclosure" AND ethics	"wounded healer" AND therap* OR "therap* practice" OR "counsel* practice" "meaning-making" OR "assumptive world"	"qualitative research" OR "qualitative research" AND studies AND bereavement Ethics AND bereavement AND research
Humanistic therap* AND "personal experience" AND bereavement OR loss OR grief	"Person-cent* counsel*" AND "personal loss" AND "effect on" OR "impact on" AND "clinical practice"	"Person-cent*" OR "client-cent*" AND empathy OR connection AND "therap* relationship"	"Humanistic therap*" AND phenomenol* OR qualitative research AND loss OR grief

APPENDIX 3

Table 2 Literature Search: Key texts

Thanatology	<ul style="list-style-type: none"> • Attig, T. (2011). <i>How We Grieve: relearning the World</i>. (Revised ed.). NY: Oxford University Press. • Neimeyer, R.A. (Ed.). (2001). <i>Meaning Reconstruction and the Experience of Loss</i>. Washington DC: APA. • Parkes, C.M. (2009). <i>Love and Loss: The Roots of Grief and its Complications</i>. London: Routledge. • Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H. (Eds). (2001). <i>Handbook of Bereavement Research: Consequences, Coping and Care</i>. Washington DC: APA. • Stroebe, M.S., Stroebe, W. & Hansson, R.O. (Eds). (1993). <i>Handbook of Bereavement: Theory, Research and Intervention</i>. NY: Cambridge University Press.
Therapist bereavement	<ul style="list-style-type: none"> • Gerson, B. (Ed). (1996/2001). <i>The Therapist as a Person</i>. London: Routledge.
Research methods	<ul style="list-style-type: none"> • Bond, T. (2004). <i>Ethical Guidelines for Researching Counselling and Psychotherapy</i>. Rugby: BACP. • Kvale, S. & Brinkman, S. (2009). <i>Interviews</i>. (2nd ed.). London: Sage. • Langridge, D. (2007). <i>Phenomenological psychology: Theory, Research and Method</i>. Harlow: Pearson Educational Ltd. • McLeod, J. (2003). <i>Doing Counselling Research</i>. (2nd ed.). London: Sage. • McLeod, J. (2001). <i>Qualitative Research in Counselling and Psychotherapy</i>. London: Sage. • McLeod, J. (2011). <i>Qualitative Research in Counselling and Psychotherapy</i>. (2nd ed.). London: Sage. • Willig, C. (2008). <i>Introducing Qualitative Research in Psychology</i>. (2nd ed.). Maidenhead: Open University Press.
IPA	<ul style="list-style-type: none"> • Smith, J.A., Flowers, P. & Larkin, M. (2009). <i>Interpretative Phenomenological Analysis: Theory, Method and Research</i>. London: Sage. • Smith, J.A. (Ed.). <i>Qualitative Psychology: A Practical Guide to Research Methods</i>. (2nd ed.). London: Sage.
Impact on therapy	<ul style="list-style-type: none"> • Mearns, D. & Cooper, M. (2005). <i>Working at Relational depth in Counselling and Psychotherapy</i>. London: Sage. • Rogers, C.R. (1980). <i>A Way of Being</i>. Boston, Mass: Houghton Mifflin. • Skovholt, T.M. & Ronnestad, M.E. (1995) <i>The Evolving Professional Self</i>. Chichester: Wiley.

APPENDIX 4

Table 3 Literature Search: Websites and Databases

Personal library	<ul style="list-style-type: none"> • CPR (2008-2011) • Therapy Today (2009-2011) • Personal textbooks
University of Chester library	<ul style="list-style-type: none"> • Journal of Person-Centered and Experiential Psychotherapies
Online databases accessed via University of Chester library/Athens	<ul style="list-style-type: none"> • CINAHL Plus with Full Text • eBook Collection • PsycARTICLES • PsycBOOKS • PsycINFO • Psychology and Behavioral Sciences Collection
Other websites/databases accessed	<ul style="list-style-type: none"> • British Association for Counselling and Psychotherapy (BACP) • British Association for the Person-Centred Approach (BAPCA) • COPAC National, Academic, and Specialist Library Catalogue • Google • Google Scholar • ProQuest Nursing and Allied Health Source • ProQuest Dissertations and Theses Database • SAGE Research Methods Online • World Association of Person-Centered and Experiential Psychotherapies (WAPCEPC) • www.ipa@bbk.ac.uk • www.liv.ac.uk/library • www.phenomenologyonline • www.surrey.ac.uk

APPENDIX 5

Table 4 Literature Search: Examples of journals accessed for literature search. [For definitive list see References].

Journals relating to thanatology and related topics	<ul style="list-style-type: none"> • Death Studies • Mortality • Omega • Palliative Medicine
Journals relating to articles on therapist bereavement	<ul style="list-style-type: none"> • Journal of Contemporary Psychotherapy • Journal of Loss and Trauma • Psychoanalysis and Psychotherapy • Professional Psychology: Research and Practice • The Humanistic Psychologist
Journal articles relating to Interpretative Phenomenological Analysis (IPA): <ul style="list-style-type: none"> - Research studies - Evaluation and contribution of IPA to qualitative research 	<ul style="list-style-type: none"> • British Journal of Psychology • Counselling Psychology Quarterly • Health Psychology Review • Journal of Clinical Psychology • Professional Psychology: Research and Practice • Psychology and Health • The Psychologist
Journals relating to research methodology	<ul style="list-style-type: none"> • Qualitative Research in Psychology • Professional Psychology: Research and Practice • Psychotherapy Research
Journals relating to counselling and psychotherapy	<ul style="list-style-type: none"> • British Journal of Guidance and Counselling • Counselling and Psychotherapy Research • Journal of Contemporary Psychotherapy • Journal of Counseling and Development • Person-Centered and Experiential Psychotherapies • Psychoanalysis and Psychotherapy • Psychotherapy Theory, Research, Practice, Training • Therapy Today

APPENDIX 6

Table 5 Developments in thanatology from Freud to the present day

Stage/phase approaches	Task approaches	Dual-Process Model	Continuing Bonds	Meaning-reconstruction	Narrative approaches	Resilience approaches
Freud (1915[1917])	Rando (1993)	Stroebe & Schut (1999, 2010)	Field (2006a, 2006b)	Attig (2001, 2004, 2011)	Bosticco & Thompson (2005)	Bonnano (2004, 2009)
Lindemann (1944)	Worden (1983[2010])		Field, Gao & Paderna (2005)	Gillies & Neimeyer (2006)	Gilbert (2002)	Calhoun & Tedeschi (2001)
Kubler-Ross (1969)			Klass, Silverman & Nickman (1996)	Neimeyer (2000, 2001, 2005)	Neimeyer (1999)	Schaefer & Moos (2001)
Bowlby (1980)			Klass (2006)	Neimeyer, Baldwin & Gillies (2006)	Walter (1996)	
Parkes (1972[1998])			Stroebe & Schut (2005)			

APPENDIX 7

Adverts for research participants

Advert for June issue of Therapy Today

HUMANISTIC/person-centred therapists sought to participate in MA qualitative research study exploring therapists' experiences of a significant personal bereavement (excluding client death) and its impact on their therapeutic practice. Participants should be currently practising as a therapist and have a minimum of two years experience. Participation involves taking part in a short initial meeting, and a semi-structured interview of approximately 90 minutes. No travel necessary. Contact;

100-word synopsis for BACP research website

I am seeking humanistic/person-centred therapists for an MA research study using Interpretative Phenomenological Analysis (IPA). My study will explore humanistic therapists' 'lived experiences' of a significant personal bereavement (excluding the death of a client) and its impact on their therapeutic work with clients. Research in this area is sparse with little representation of the perspectives of humanistic practitioners. Participation would involve a short initial meeting with participants (if required), followed by a semi-structured interview of approx. 90 minutes. Participants should be currently practising and have a minimum of two years post-qualifying experience. Every effort will be taken to ensure confidentiality and the well-being of participants during the research study. Contact

APPENDIX 8

Letter to interested respondents

Address

Date as postmark

Dear

Thank you for responding to my advert in Therapy Today for research participants. I enclose an information sheet and also a short questionnaire for you to complete, if you think you might be interested in participating in the research study, together with an s.a.e. Please don't hesitate to contact me if you need further information. Many thanks.

Kind regards,

Jeanne Broadbent

APPENDIX 9

Information Sheet for Prospective Research Participants

The researcher – Jeanne Broadbent

I am a qualified counsellor and hold a Post Graduate Diploma in Counselling (Dist.). My course of training focused on the Person Centred Approach. My experience has included working with clients as a bereavement counsellor in a hospice, and also within private practice. I am currently a student on the MA in Counselling Studies in the Department of Social Studies and Counselling at the University of Chester. I have recently submitted a research proposal for my dissertation and am now seeking participants. I am a member of BACP and adhere to the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP 2010). I aim to conduct the research project in accordance with the Ethical Guidelines for Researching Counselling and Psychotherapy (Bond/BACP 2004).

Title of study, rationale and aims

The working title of my research study is:

A qualitative study of humanistic therapists' experiences of significant personal bereavement and the impact on their therapeutic practice. A phenomenological study using Interpretative Phenomenological Analysis.

My interest in this area arose from my own experience of bereavement and my work as a bereavement counsellor. I discovered that whilst there is a substantial body of research on client experiences of bereavement, there is comparatively little research in the area of therapist bereavement. Research suggests that the personal life experiences of therapists can influence their therapeutic work with clients, and so the aim and purpose of my research is to explore what this might mean for a small number of participants. I have chosen to adopt a phenomenological research methodology in order to reveal as closely as possible the 'lived experience' of the participants. The study will hopefully contribute to the existing literature in this area, and may further the professional understanding of how therapist variables can impact upon the therapeutic relationship. There may also be implications for training and supervision.

Participants

I am seeking participants who are humanistic/person-centred in orientation and who have experienced a significant personal bereavement (excluding the death of a client). There must have been a period of between one and five years since the bereavement. The bereavement could have occurred prior to counsellor training or working as a counsellor. Participants must be currently practising full/part time

therapists with a minimum of two years' post-qualifying experience. I enclose a questionnaire based upon my inclusion criteria which I would be grateful if you would complete if you are interested in taking part in the study. The first five respondents who fulfil the inclusion criteria will be invited to participate in the study.

Participant involvement

Due to the sensitive nature of the research topic selected participants will be invited to an initial meeting with the researcher (if required) so that any questions participants may have can be addressed and clarified. Participants will also have the opportunity to preview the interview questions. Following this meeting, participants will take part in a semi-structured interview of approximately 90 minutes (to include time for a short debriefing) which will be digitally recorded. Key areas of focus will include exploring the lived experience of bereavement for the individual participant, and how this experience impacts upon or informs his/her therapeutic work with clients. Following the interview, participants will be invited to check their transcripts for accuracy. Participants will be able to choose the location for the interview. **Participants can withdraw from the study at any time without explanation and all data collected up to that point will be destroyed/returned to the participant for disposal.**

Data collection and confidentiality

The primary means of data collection will be by recorded interview with participants. The interviews will then be transcribed and the data analysed. Participants' identifying features (name, location etc.) will be removed and all data will be anonymised using a coding system and/or pseudonyms. Audio recordings will be kept until the award of the MA and then destroyed. Data in hard copy will be kept in a secure filing system, and electronic data will be password protected. The researcher and her research supervisor will have primary access to the anonymised data. University internal markers and external examiners will also have access to data. All hard data will be kept for five years in accordance with University requirements. The completed dissertation will be available at the University of Chester, and may also be available electronically.

Ethical approval

The research proposal has been approved by the University of Chester's Department of Social Studies and Counselling Ethics Committee. The research will be monitored by my research supervisor Dr. Rita Mintz.

Risks to participants

As this is a sensitive area of exploration there is the potential for participants to experience distress particularly during the interview when painful memories may be triggered. In the event of a participant experiencing distress, the interview would be terminated. The researcher will ensure that appropriate sources of support are

identified, and participants will be advised to inform their supervisors of their participation in the project.

Benefits to participants

This is an under-researched area and therefore it may serve to give the participants a voice and in that sense it could be an empowering experience. Participants will be given the opportunity outside of supervision or personal therapy to reflect deeply on the ways in which their personal experience informs their professional practice, and this may lead to an increased personal understanding.

Further information

If you require any further information, or are interested in participating in the research, please contact Jeanne Broadbent at

Should individuals have any concerns about the conduct of this research they can contact my research supervisor, Dr. Rita Mintz

Research Questionnaire based on inclusion criteria

What counselling qualification(s) do you hold? _____

Are you a current member of BACP? _____

How would you describe your theoretical orientation? (For example, humanistic, integrative, psychodynamic etc). _____

Are you currently practising as a full/part time counsellor/therapist? _____

How long have you been practising? _____

Are you receiving regular supervision? _____

Have you experienced a significant personal bereavement (excluding the death of a client)? _____

How long ago did the bereavement occur? _____

Are you currently receiving counselling in respect of this bereavement? _____

Are you able to converse with reasonable fluency in English if English is an additional language? _____

APPENDIX 11

LETTER INVITING RESPONDEES TO PARTICIPATE IN THE RESEARCH STUDY

Tel:

Address

Email:

Date as postmark

Dear

Thank you for returning the questionnaire based upon the inclusion criteria for my research study. I would like to invite you to participate in the study and I enclose a Consent to Research form which I would be grateful if you would sign and return to me. Should you give consent to participate in the project, I also enclose two copies of the consent form for the audio taped interview; one for your own records, the other for myself. Please sign both copies of the form. Prior to carrying out the interview, I would like to repeat my offer of a pre-interview meeting in order to clarify any details of the research about which you are unsure. However, if you feel that this is not necessary, we can arrange a mutually convenient date and time for the interview at a location of your choice.

Due to the sensitive nature of the research, and with regard to self care, I would suggest that you inform your supervisor of your intended participation in the study, although this is entirely your choice. Prior to the interview itself, I will send you a copy of the interview questions so that you will have some idea of the areas to be covered. However, this is intended as a guide and the main purpose of the interview will be to explore your own individual experience of bereavement and its impact on your therapeutic work with clients. In order to analyse the data for the research, the interview will be digitally recorded and then transcribed. All data collected will be anonymised and every effort will be made to ensure complete confidentiality. You will be offered the opportunity to review the written transcript and you have the right to withdraw all or parts of the data should you so wish. Upon completion of the research, the audio recording will be erased.

Please contact me by telephone or email if you would like to arrange a pre-interview meeting or, alternatively, a date and time for the interview itself. Thank you very much for your interest in this research study and I look forward to hearing from you.

Kind regards,

Jeanne Broadbent

Encs.

APPENDIX 12

RESEARCH CONSENT FORM

Title of Study: *A qualitative study of humanistic therapists' experience of a significant personal bereavement and the impact on their therapeutic practice. A phenomenological study using Interpretative Phenomenological Analysis.*

Name of Researcher: Jeanne Broadbent

Name of Participant:

- I confirm that the nature of the research study has been fully explained to me.
- I confirm that an information sheet was provided which outlined the details of the research study and my role as participant.
- I confirm that due to the sensitive nature of the study, the researcher has suggested that I inform my supervisor of my intended participation.
- I confirm that I have been offered an opportunity by the researcher for further explanation and/or clarification of the details of the study.
- I believe I have been given sufficient information about the nature and purpose of the research study to give my **informed consent** to participate.
- *I confirm that my right to withdraw from the interview and/or study at any time and without giving a reason or explanation has been made clear.*

Signature of participant:

Date:

APPENDIX 13

UNIVERSITY OF CHESTER

MA in Counselling Studies

Consent Form - Digital Audio Recording of Interview

I hereby give consent for the details of a written transcript based on a digitally audio recorded interview between myself and to be used in preparation, and as part of, a research dissertation for the MA in Counselling Studies at the University of Chester. I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential and separate from the research data. I further understand that the transcript may be seen by the Counselling Tutors and the External Examiner for the purpose of assessment and moderation. I also understand that all these people are bound by the British Association for Counselling and Psychotherapy (BACP) Ethical Framework for Good Practice in Counselling and Psychotherapy.

I understand I will have access to the transcribed material should I wish to, and would be able to delete or amend any part of it. I am aware that I can stop the interview at any point, or ultimately withdraw the interview before the publication of the dissertation. Upon completion of the research the recording will be offered to me or, by prior arrangement with me, destroyed. Transcripts will need to be kept by the University for a period of five years after which time they will be destroyed.

Excerpts from the transcript will be included in the dissertation, but will exclude any personally identifiable material. Copies of the dissertation will be held at the University of Chester and may be available electronically via the University's digital archive system.

Without my further consent some of the material may be used for publication and/or presentations at conferences and seminars. Every effort will be made to ensure complete anonymity.

Signed [Participant].....

Date

Signed [Researcher]

Date

APPENDIX 14

Table 6 **Characteristics of Participants**

To protect anonymity, participants are referred to by self-selected pseudonyms.

Participant	Harper	Jessica	Sophie	Goldie
<i>Counselling Qualifications held</i>	Dip. in PCC	Dip. in PCC	PG Dip in Counselling	AEB/CSCT Cert in Counselling; PG Dip in Psychotherapy & Hypnotherapy
<i>Current member of BACP</i>	YES	YES	YES	YES
<i>Theoretical orientation</i>	Person-centred	Person-centred	Humanistic	Eclectic/humanistic
<i>Currently practising (full/part-time)</i>	YES	YES	YES	YES
<i>Length of time in practice post qualification</i>	3 yrs	12 yrs	7 yrs	13 yrs
<i>Receiving regular supervision</i>	YES	YES	YES	YES
<i>Experience of significant personal bereavement</i>	YES	YES	YES	YES
<i>Currently receiving therapy in respect of this bereavement</i>	NO	NO	NO	NO
<i>Length of time since bereavement</i>	8 yrs	10 yrs and 5 yrs	5 yrs	15 months
<i>Able to converse with reasonable fluency in English if English an additional language</i>	N/A	N/A	N/A	N/A

APPENDIX 15

Interview Schedule (as sent to participants)

Research question 1

1. Could you tell me briefly how you came to be a counsellor?
2. Can you tell me about your theoretical orientation and the work you do as a counsellor/therapist? For example, the setting(s) you work in, the client base, presenting issues etc., long or short term work ?
3. [As a humanistic/person-centred practitioner ...] What feels to be most important to you in your therapeutic work with clients?
4. I wonder if you could tell me in as much detail as you can about your own experience of significant personal bereavement?
5. Can you describe how this experience affected your sense of self, identity, world view, beliefs and assumptions?
6. How have you made, and continue to make, sense of your bereavement experience?

Research question 2

7. How would you describe the ways in which your personal experience of bereavement and grief positively impacts upon your way of working and being with your clients?
8. Can you describe any negative impact that your experience has had on your practice?
9. Are you aware of any occasions when you felt it was/might have been appropriate to disclose details of your own loss in the therapeutic context?
10. In what ways does the impact of your bereavement experience on your therapeutic work change over time?
11. Can you tell me what role supervision has played with regard to your personal experience of bereavement and your therapeutic work with clients?
12. Is there anything else that you feel is relevant to your experience of bereavement and its impact on your therapeutic practice?

APPENDIX 16

Interview Schedule (with prompts) – Researcher copy

Thank you ----- for agreeing to participate in this research study and this interview. As you know this is a sensitive topic so if you want to stop the interview at any time, just let me know. I'm really interested in what you have to say and there are no 'right' or 'wrong' answers. The questions are just a guide. Take your time to think and speak. I won't say very much – though I may prompt you sometimes – but that's because I want to try and understand how *you* make sense of your experience.

Research question 1

1. Could you tell me briefly how you came to be a counsellor? [*Narrative*]
2. Can you tell me about your theoretical orientation and the work you do as a counsellor/therapist? [*Descriptive/structural*]

Prompts: the setting(s) you work in, the clients you work with and their presenting issues etc., and if you do long or short term work or both?

3. [As a humanistic/person-centred practitioner ...] What feels to be most important to you in your therapeutic work with clients? [*Evaluative*]

[As you know, my research is looking at therapists' experiences of bereavement and its impact upon their practice ... So do you feel okay to move on? If at any time you want to stop the interview, just let me know.]

4. I wonder if you could tell me in as much detail as you can about your own experience of significant personal bereavement? [*Descriptive/narrative*]

Prompts: nature of the death; relationship to participant; initial responses and feelings of grief; impact on other relationships; impact on functioning and well-being.

5. Can you describe how this experience affected your sense of self, identity, world view, beliefs and assumptions? [*Contrast/comparative*]

Prompts: feelings; change in world view/personal assumptions/beliefs; self-concept/identity/role.

6. How have you made/how are you making sense of your bereavement experience? [*Contrast/comparative*]

Prompts: adjustment to the death; changing relationship with deceased over time; internal changes; perception of self; qualities of resilience.

Research question 2

7. How would you describe the ways in which your personal experience of bereavement and grief positively impacts upon your way of working and being with your clients? [*Descriptive*]

Prompts: use of self; use of core conditions – congruence, empathy & UPR; experience of relational depth; connection; ability to reflect; therapeutic relationship.

8. Can you describe any negative impact that your experience has had on your practice? [*Descriptive*]

Prompts: over-identifying with client's material; responding from own frame of reference; emotional 'flooding'; avoidance of issues that might trigger own emotions.

9. Are you aware of any occasions when you felt it was/might have been appropriate to disclose details of your own loss in the therapeutic context? [*Evaluative/reflective*]

Prompts: (depending upon response to Q. 9 above) boundary/ethical issues; dealing with direct questions/condolences from client; your perception of how your decision to self-disclose affected the therapeutic relationship.

10. In what ways does the impact of your bereavement experience on your counselling practice change over time? [*Contrast/comparative*]

Prompts: passage of time since the bereavement; adjustment to the death and self-healing/diminution of grief; ability to use experience in different way as time passes.

11. Can you tell me what role supervision has played with regard to your personal experience of bereavement and your therapeutic work with clients? [*Evaluative*]

Prompts: ability to be open with supervisor regarding impact on client work; attitude of supervisor; boundary issues with personal therapy; self-care.

12. Is there anything else that you feel is relevant to your experience of bereavement and its impact on your therapeutic practice that you would like to add before we finish?

Thank you very much for participating in this interview and for sharing your experience with me today. I will send you a copy of the transcript for you to check in due course. I'm also going to give you a list of resources for bereavement support for you to contact if you need to.

APPENDIX 17

Procedure of data analysis illustrated with dated extracts from Reflective Research Journal

(Note: There has been some minor editing of the extracts to ensure grammatical and syntactical accuracy).

“Data analysis follows a process of empathic immersion in participant subjective worldviews, and an ‘outside’ perspective of thinking about the data and comparing across cases” (Lewis (2008 p.67).

Following completion of the interviews, the digital recordings were transcribed verbatim, and included paralinguistic features of oral language such as hesitations, repetitions, pauses, sighs, ‘fillers’ such as ‘like’ and ‘you know’, and ‘continuers’ (‘er’ and ‘um’).

18.9.11

This is all very challenging! Am aware of some resistance to starting the analysis. The long transcripts appear daunting and I’m not sure how many themes I’m supposed to identify. Just read Braun & Clarke’s (2006) paper on thematic analysis which is quite useful, but perhaps the reading is also an avoidance strategy!

*Have realised that my research differs somewhat from other IPA studies (which focus predominantly on health-based issues) and which seem to focus on participants’ lived experiences in the here-and-now, and which incorporate a focus on the comparison between the ‘before’ and ‘after’. My study looks at a previous experience (of between 18 months and 10 years from the present day) and thus the bulk of the narrative is a reflective one that includes the participants’ reflections from the position of hindsight – though there’s also a ‘before’ and ‘after’ that exists on different levels: factual, environmental, circumstantial, emotional, **temporal** etc. [Smith et al (2009) very helpful here. P.98]*

Starting with one transcript, I read and re-read the whole document at a semantic level in order to gain a ‘feel’ for the overall content. The next step was to carry out an

'initial coding' of the transcript using the right-hand margin, with exploratory comments on descriptive, linguistic and conceptual aspects of the text. (Smith et al 2009). (Appendices 18, 19, 22: Tables 7, 8, 11, pp.) I also made a specific note of any metaphors, or other examples of figurative language or idiomatic phrases used by the participants, as clues to gaining insight into the participants' experiences. Whilst engaged in this process, I used my Reflective Research Journal to note down initial thoughts, feelings, questions, observations, and tentative interpretations. (Roulston 2010).

25.9.11

*Iterative re-reading of Harper Pages 1-25. A very long transcript and rich in detail. Lots coming into my mind. Strong relationship between Q.1 and the exploration of her bereavement experience – because of the chronology of events. Uses specific **temporal markers** to locate important events. Consider main sequence of events in the narrative.*

TIME

FEAR

SELF CONCEPT/PERCEPTION OF SELF

HEAD NOT HEART

A COPER

ALONE

2.10.11

There is a shift in Research Focus 2 from the subjective, personal recollections/reflections to a more objective and immediate focus on the participants professional practice, and how their experience impacts on the 'self' that they bring to the therapeutic relationship. My themes then for Research Qu 1 will be/may be?? unique to each individual participant and I may not be able to identify convergences as such – except in a more general sense. Research Qu 2 however, might reveal more explicit convergences/divergences. [Do the themes have to relate to each question on the schedule? How do I determine 'prevalence'? How will I recognise a main theme and what wording do I give it? E.g. the participant's own words – my preferred option!]

The Braun & Clark (2006) paper writes of the active participant of the researcher rather than themes 'emerging' or waiting to be 'discovered'. This seems to fit with the hermeneutic aspect of the methodology – the recognition of the researcher's subjectivity and the acknowledgement that all interpretations will therefore be tentative and speculative in nature. Both Smith et al (2009) and Willig (2008) affirm that the

researcher's subjectivity will inevitably influence the interpretation in that the researcher's interests will foreground particular aspects of the analysis. Another lens?? I could link it to theory too (see Smith et al 2009). E.g. Harper's denial of her husband's death which is linked to her denial of what was going on in their marriage and to her perception of self at that time. The death is seen almost entirely through the eyes of her children – or through the lens of her role as parent, not wife or partner. There's a strong sense of 'coping alone'; of her inability to confide in others. Shame? This is addressed later in terms of her self-perception – i.e. looking at the transcript in terms of the hermeneutic circle (parts to whole and vice versa).

6.10.11 (Tutorial today)

Wrestling with how to achieve the 'abstraction' needed in moving from the initial coding to identifying emerging themes. Difficult to move from the descriptive to the interpretative though some tentative interpretation/questioning has been included in the initial coding. [Ask supervisor about this.] Smith et al (2009) seem to define their themes in psychological language, but I'm not a psychologist! Also, much of the corpus of research using IPA is related to research in health and deals with participants' responses to a particular issue, e.g. the impact of a diagnosis. There is a sense that these studies are more immediate in terms of temporality whereas my study covers a longer time frame and therefore is concerned more with a continuing process. Should I be thinking about using a framework related to bereavement and to the evolving process of grieving? What about existential issues? Changes in the self as a result? My own intuitive sense is to link the themes to literature on bereavement and also to current discourses in the PCA. [Ask supervisor. Smith says that some studies use the theory more explicitly than others. IPA not meant to be prescriptive. Do I need to allow myself to be more flexible??]

Having again re-read the transcript, I then used my initial codes to document emerging themes in the left-hand margin. (Appendices 20, 221, 23: Tables 9, 10, 12, pp.)

10.10.11

Super-ordinate themes will be different for each participant though. Need to wait until I've analysed all the transcripts before looking across and identifying master these for whole group. Difficult to achieve this 'bracketing', however. Refer to Finlay's (2008) paper on the 'dance' between the reduction and reflexivity!!

15.10.11

Finished first 'reduction' and now onto 2nd reduction (Harper). The part relating to the impact on therapy is very rich – some lovely metaphors – and links well to Qu. 1. The way it all fits together is amazing! The story has a clear structure: beginning, middle and end with temporal markers throughout to orientate the listener/reader. Not sure how I'm going to cluster the themes as there seem to be so many, but one theme stands out – the process of change: change through the grieving process; through her changing self; through her changing therapeutic practice. They seem almost symbiotic in nature. One tentative interpretation is that Harper's denial of the true nature of the abusive nature of the relationship with her husband (and her pattern of managing on her own and keeping quiet about what was happening) in some way contributed to H's self-disenfranchisement of the grief she felt following his death. [Kauffman] She therefore displaced/denied her own feelings and focused solely on her children, perceiving her husband only as 'the children's father'. This strategy enabled her to stay in control and effectively shut down her own feelings. A contradiction also emerges in that there are indications that Harper did not want to cope alone and where she voiced a strong need for support. [Perhaps she couldn't allow herself to ask for this?]

Next, I typed up the emerging themes in chronological order of their appearing in the transcript, cut them out, arranged them into 'clusters', and then stuck them (or handwrote them) onto large sheets of paper. (Smith et al 2009, p.96). (Appendices 24, 25 a, b, c, pp.) This facilitated a visual and spatial exploration of how the themes related to each other. It also enabled me to reallocate particular themes and to disregard others.

21.10.11

Carried out Smith et al's (2009) clustering of themes (Harper) using large sheets of paper and clustering according to temporal order of events. This was very useful in providing a visual picture and in identifying where related themes fitted together. A time-consuming process, but one that was very beneficial. Next step is to identify the super-ordinate themes and their constituent cluster sub-themes. Challenging!! Refer to Willig (2008) again and to Smith et al (2009) as both texts contain some useful examples of summary tables of themes. Need to try and capture the essence of the experience in the super-ordinate themes – abstraction??

The most challenging aspect of the analytic process was to move the analysis to the higher levels of 'abstraction' and 'subsumption' (Smith et al 2009, pp.96 & 97) in order to identify patterns between emergent themes that would lead to the development of super-ordinate themes. Although similar themes emerged at differing points in the transcript, I was able to identify particular themes and patterns that could be grouped together in a more unifying and coherent way. However, I was also aware that this process disrupted the temporal nature of the narrative.

24.10.11

Have tentatively clustered Harper's and Jessica's themes today in terms of their responses to the bereavement; to social dimensions; and to challenges to assumptive world (e.g. Harper's loss of personal 'innocent faith'; Jessica's loss of trust in personal and societal assumptive world). Something like that(!) – but it's a work-in-progress and I keep returning to the text for clarification and cogent quotes that best illustrate the themes. Am now going to brainstorm what I think are the main objects of concern for H and J in their accounts; what does their experience mean to them? What has their journey been like for them as individuals? [Repeat process with Sophie and Goldie.]

For example, there were a number of themes related to the initial impact of bereavement and the participant's unique responses to this. Similarly, an important theme emerged related to the participant's personal and professional growth and the relationship of this to their practice. Interestingly, the interrelated themes of 'time' and 'change' also emerged as being important elements, although these themes were expressed in different ways. At each point in the analytic process, I operated the 'hermeneutic circle' by moving back and forth between the transcript and themes to ensure that the themes were firmly grounded in the participant's 'voice'. Finally, I produced a table identifying the superordinate and sub-themes for each participant, together with illustrative in vivo quotes and page/line references. (Appendices 26-29: Tables 13-16, pp). I noticed that at this stage in the analysis, a small section of text -

even a short phrase - took on greater significance in relation to the holistic meaning of the narrative, and this was exciting as it cast new light on the analysis up to that point. Another challenge I became aware of was the difficulty in 'bracketing off' what I already knew about the evolving analysis in order not to pre-empt new themes arising from subsequent transcripts. This challenge for the researcher is eloquently expressed in Finlay's account of the 'dance' between the reduction and subjectivity

27.10.11

After many hours poring over the clustered themes and reducing them further, I had a 'Eureka' moment! Began to see some super-ordinate themes emerging that could possibly capture the essential details of the participants' stories. Started with Harper, and finally came up with a draft 'summary table of themes' for her as an individual. This process follows the iterative case study approach advocated in IPA and I will follow this process with the other participants. Am not feeling quite so concerned about convergence at this point as the summaries for each participant will be different with each summary reflecting their individual experiences. [Speak to supervisor regarding the production of the master themes.] Don't want to lose the individual experience for the sake of the more global perspective. Smith says that this is one of the main challenges of IPA – to retain the particularity of the individual experiences whilst also presenting a wider picture of the whole group. Producing the table took a long time, especially identifying the 'richest' in vivo quote to illustrate sub-themes, but worth it in the end. The hermeneutic circle was well in evidence here!

The iterative and inductive process of analysis outlined above was repeated for each participant's transcript, allowing new themes to emerge with each case. Once this had been achieved, I then looked for patterns and connections, differences and divergences across all four cases in an attempt to arrive at a table of master themes that represented the data set as a whole. (Smith et al 2009). This was a time-consuming and at times frustrating process as it demanded that I be selective. Deciding upon the master themes also involved a return to the transcripts themselves to ensure that themes were solidly grounded in the data, i.e. the participants' voices. I then again asked myself the question I had asked throughout my study: 'What are the main areas of concern for **these** four participants in **this** study and how best can

their phenomenological experience be captured in the form of master themes given the analysis of the data so far?’

Some ideas for 3 or 4 over-arching ‘domains’ or ‘broad organising categories’ (Smith et al 1999) or master themes are running around in my head. Keep trying to capture these in a diagram. These are:

- *Time*
- *Evolving grief process*
- *Personal and professional integration/synergies/interface ...?*
- *Impact on therapeutic practice*
- *Change/transition?*

Having asked the question, I returned to the individual summaries and endeavoured to distil these into four over-arching master themes that seemed to encapsulate the main findings of the study bearing in mind that master themes are not selected purely on their prevalence in the data. (Smith, Jarman & Osborn 1999). Thus, following a good deal of revision and checking against the original transcripts, I finalised a table of master themes for the group. (Appendix 30: Table 17). (These are also represented in the diagrammatically in Fig.1, Chapter Four, page in order to convey the interrelatedness of the master themes).

APPENDIX 18 (Table 7) Original Transcript (Harper) (Pages 5-8 lines 126-249)	Initial coding: Extract 1
<p><i>You mentioned that 2003 was y'know a significant time [H: Mmm] - d'you want to tell me a little bit about your experience of ...</i></p> <p>H: ... of the bereavement. I'm going to have to go back a <i>little</i> bit because otherwise it won't make much sense at all ...</p> <p><i>I: That's fine, you just tell it as it is to you.</i></p> <p>H: So got married in '92 and come/ I would say my my youngest child was born in 97'. Erm, myself and my husband we were married over in Spain, he was Spanish speaking, had been an addict, erm and I'd met him in the drugs and alcohol and everything rehabilitation centre. I'd gone out there with the express desire that I would not meet <i>any</i> bloke over there because that was a very silly thing to do, but erm he'd been/ it was a Christian organisation, he'd been teaching, preaching, been clean for 5 years when I knew him. Erm we got married erm, and erm, so got married in '92, summer of '92, had my daughter in erm July of '94 – yeah – then I fell pregnant with my middle child, my son, my first son and he was born in the September '95. Before that we actually decided to actually leave the community setting where we were both working and come back to ----- because that's where I had family, he/he had estranged family in Spain. So I came back, well we both came back, so I came back, married with one child and one about to be born. Erm my husband <i>spoke no English</i> and we were sort of starting off from from zero really, I had my parents, but when we came over we had to find a house to rent and furnish it and everything else as well as being sort of seven eight months pregnant and <i>I was the only one who could speak the language</i>. But, that transition went okay</p>	<p>Contextualising narrative in a chronological format.</p> <p>Factual information conveyed.</p> <p>Husband had been an addict.</p> <p>Had gone to Spain with 'express desire' of not meeting '<i>any</i> bloke' as this was 'a very silly thing to do'. [Why? Hint of a judgemental voice here? Or someone else's judgemental voice? Influence of past experience?]</p> <p>Describes where they met and what he did – and fact that clean for 5years. [Was this important to Harper? How significant was the fact that it was a Christian organisation?] A sense of struggling to be specific about dates – hesitant repetitions of 'erm' .</p> <p>Interesting change from 'I' to 'we' to 'I'. Returned to UK and faced with prospect of setting up new home. Husband spoke no English. (Repeated below) Starting off from zero, had to find and furnish a house, Harper 7-8 months pregnant and with one other young child, only one who could speak the language. Use of 'only' emphasises this point – [and this responsibility? A marked change from the person who went out to Spain with no intention of meeting a man.]</p> <p>A sense of it being a big transition, but one that went okay. [Harper as someone who always</p>

erm and then (*slowing down*) erm, had our last child in '97 August of '97 (*takes a deep breath*) and I think my husband was getting a bit *bored* with family life 'cos I was a bit busy with three children in three years and he/he was a bit of a male, bit of a male, (*laughs*) bit of a male Spaniard and the children were really *mine*, erm he tried his best, but they were predominantly my children (*quickly*) he wanted them, but I think he found that they took up quite a lot of time as you might imagine with three under/ well, a daughter who was three and two months when the third one was born, so yeah, they are quite demanding. Erm he'd made some friends erm he'd been to ESOL classes and he'd done some voluntary work within the church so he'd/he'd made some friends but, one or two were Spanish speaking but not all of them and he began to (*slowing down a bit*) secretly smoking and just/ the marriage just got/ there was tensions in it and he began to drink a bit more and go out and so it it/ looking back it became more abusive than it had been before, and got to the point where (*pause*) erm - not at the time I wasn't aware of it - got to the point where I was very aware that I was petrified of him and/ but hadn't quite equated that that wasn't quite normal.. used to erm wake sort of in the evening when all three kids were in bed and he was out probably at a friend's erm often with the car, I knew he was drinking he'd been drinking before he left so he was drunk all the time erm and it was like crumbs how do I get these/ and I would go through this sort of (*matter-of-factly*) how do I get *these* three kids out of *this* house if he comes back and is abusive, (*intake of breath*) and I just ...

I: (Questioningly) Sense of/ a real sense of fear..?

A real sense of fear, but that's only with hindsight. [*I: Okay*] I knew I was thinking it at the time but it was just like well, you've got to stay, I didn't want to get *divorced*, I'd married for life and that was very much a big thing for me.. erm, and .. once or twice I (*pause*) I'd wondered whether he'd taken anything else other than just drink erm, but had no proof/ I'd

copes?] (P.3 lines 133-157)

A sense here of Harper encountering difficult terrain as evidenced by her deep intake of breath and the slowing down of her narrative. The phrase 'a bit busy ...' underestimates the demands three young children were making on her. Said ironically. Slight shift in narrative tone here. The word 'bored' implies an understatement and has a slightly sarcastic nuance. [*Is there an underlying feeling here of being let down?*]

Refers in line 163 to the cultural difference that might have existed – 'bit of a male Spaniard'. Describes the children as 'predominantly my children', though quickly justifies that her husband wanted them too. [*Is she justifying that to herself? What might it mean to Harper that they are her children? Was husband self-excluding from family unit or did H exclude him in some way*] Phrase 'you might imagine' is said rhetorically and somewhat ironically.

Describes the worsening tensions in the marriage and her husband's gradual withdrawal from [*rejection of?*] the family. Slows down when describing his secret smoking and drinking. Use of 'just' emphasises Harper's struggle to explain this difficult period. Use of 'the' as opposed to 'my' or 'our' marriage objectifies the relationship and distances H's role in it.

With hindsight, gradual awareness that relationship had become more abusive – 'looking back ...' Explains that not aware of this at that time as signalled by the pause in line 177, but reaches the point where 'very aware' that she was 'petrified' of him. Not aware that this wasn't 'quite normal'. [*In denial? Aware versus unaware? Confusion?*]

Spent time planning how to escape – but husband would often take the car so no means of escape there.

Going over in her mind how she would get 'these three kids out of this house' if he came back and was abusive. Use of pronouns 'these' and 'this' emphasises specificity of intention. Fear evident in her intake of breath which contrasts strongly with the matter-of-fact way she describes these feelings. [*Is this Harper's way of dealing with the fear she feels? Also her instinct as a mother to protect her children.*]

Tails off .. [too difficult to complete sentence?]

Describes her real sense of fear – but in hindsight.

Didn't want to get divorced. Emphasis on 'divorced'.

Had married for life and this was very important to her. [*Did this conflict with her desire to leave the abusive relationship and therefore conflict with her perception of herself? She hadn't wanted to parent on her own – see lines 26/27. Also a conflict with religious beliefs?*]

Change in direction here. The pause signals an important shift in the narrative and Harper's intonation changes and slows.

<p>seen him/he'd told me the Christmas of 2002, no Christmas 2001 he'd told me that erm he was going to leave for another woman, but could we have Christmas together.. I spoke to a friend and yes, okay (<i>sighs</i>) we'll keep it all together, and we did (<i>intake of breath and sigh</i>) <i>because that's what I did</i> (<i>self-deprecating</i>) and he never did go but he was <i>all over the place, so all over the place</i>, quite abusive in front of the children, but it was always on a verbal/ on a yep on a verbal level never/ I was always concerned that he would (<i>gives each word equal emphasis</i>) physically assault me <i>but he never did physically assault me</i> whilst we were still living together .. and so it got to sort of June time and I/ I think my body had just given up so I had a massive panic attack and went to A&E and then came home and spent the weekend and he/ [I] spent the weekend <i>absolutely shattered</i> by which time my parents/ my parents weren't aware of where the marriage was at, but my dad had taken me to A&E so I guess he knew that something wasn't quite right, but didn't know why erm and my husband during that weekend kept on blaming me that it was all in my head that I was making it all up blah-de-blah-de-blah so I started counselling and ended up on <i>very mild</i> anti-depressants erm just to cope really and erm discussed with my husband that he really needed to get his alcohol problem sorted out, so he went off to a well, went off .. I'd refused to go on holiday with him and the children, it was like no, you mucked up last year, you were drunk and everything , it's like no, I'm not going, so my parents invited us to go away with them and the agreement was that during the August when we were away for a fortnight that my husband would stay at home and then he would take himself off to a rehabilitation centre that er, (<i>pause</i>) was actually in ----- erm, and it was a Christian one and the leader spoke Spanish and he would take himself off whilst we were away. I 'phoned up a couple of days before we were coming back and he still hadn't gone, and it was like you <i>need</i> to go. Er, so erm he <i>did</i> go so by the time we</p>	<p>Describes wondering (suspecting?) that husband was taking drugs. Prefaces this by saying that husband wanted to leave for another woman, but could they have Christmas together.</p> <p>Harper very resigned here, <i>sighs deeply</i> and describes how she agreed to her husband's wishes 'because that's what I did'. [Did she have another choice? What did <i>she</i> want at that time? A sense that maybe she put her own needs last? What does the phrase 'that's what I did' imply about Harper's patterns of behaviour? Sounds like she always did what was asked of her.] Describes the escalation of her husband's abusive behaviour. Repetition of 'all over the place, so all over the place' indicates how chaotic he was. Also in front of the children. [A crossing of a line here in terms of the level of abuse – and an increase in Harper's fear for her personal safety?]</p> <p>Describes the verbal abuse.</p> <p>Describes her continued concern that he would assault her physically, and emphasises each word. [Is there a sense that 'concerned' somehow diminishes the fear Harper is feeling here?]</p> <p>Body had given up; massive panic attack; absolutely shattered. [Couldn't hold it in any longer.]</p> <p>Parents not aware of seriousness of situation.</p> <p>Husband kept blaming H.</p> <p>H put on mild anti-depressants. [Emphasis on 'very mild' – is this because she saw it as a weakness? Wanted to 'cope' at all costs.]</p> <p>Husband agreed to sort out his alcohol problem.</p> <p>Harper being assertive and refusing to go away with him.</p> <p>Anxiety that husband hadn't gone to the centre. [Emphasis on 'need' reflects Harper's anxiety – and also her hope??]</p> <p>Importance of temporal markers here. [Harper thinks carefully to make sure she is accurate].</p>
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<p>came back off holiday he'd <i>gone</i>. And.. then ..(<i>thinking</i>) it must have been two weeks in, so we were coming up to being able to have a visit it was my son's/ would have been my son's 7th birthday and our 10th wedding anniversary on the 6th September, but on the 5th/ so the kids had just gone back to school, they were 5, 7 and 8 well, ----- was nearly 7, the day before his birthday, and ----- had just turned 5, and er got a 'phone call just as I'd come back home from dropping the kids off at school saying .. this was from the Spanish speaking person ..he says, your husband's really kicked off erm last night erm we've kept him overnight but he's going, he's coming home, it was like, oh! what am I going to do? So at that point I took our passports because I was concerned that he would take the kids and erm made my mind up that I was leaving ..</p>	<p>Significant dates: wedding anniversary; son's birthday; being able to have a visit. [What were Harper's hopes at this point?]</p> <p>Fear at receiving this unexpected 'phone call. Panic?</p> <p>Decided 'at that point' [<i>realising that it had gone too far?</i>] to take their passports and made up mind to leave.</p>
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<p>APPENDIX 19 (Table 8)</p> <p>Original Transcript (Harper)</p> <p>(Pages 20-22 lines 646-700)</p>	<p>Initial coding: Extract 2</p>
<p>...I had a bit of support at different points but predominantly it was, <i>(quietly)</i> well, it was me .. on my own.</p> <p><i>I: (Reflecting empathically) You on your own.</i></p> <p>H: Yep. Yes, that's how it was. Erm .. so .. I was still seeing the counsellor weekly 'cause I'd got a bit more/ bit/ different crisis .. in some ways some of the other crises had finished because at least I wasn't wondering about what would happen and would he be there and whether I'd have a 'phone call or anything like that , so .. we just got on ..<i>(flippantly)</i> as you do!</p> <p><i>I: How were you making any sense of it, of what had happened? – For you?</i></p> <p>H: I <i>didn't</i> at that point. I didn't make any sense erm <i>(pause)</i> no, I don't think there was any linking it to how how is this for <i>me</i>.. no-one was <i>inviting</i> me to go there, most definitely, there wasn't –</p> <p><i>I: Not even the counsellor?</i></p> <p>H: Well, I was very/ I was going to see/ I was still going to see her 'cause I <i>had</i> to see her, [<i>I: Yes</i>] it wasn't <i>her</i> making me go / I knew I needed to off-load so I was very much in off-load mode, it was like, yeah, this is happening, and I just couldn't go anywhere with anything y'know so yeah, I'm sure <i>(laughs)</i> I'm sure she sort of/ .. she she was fab counsellor, but, y'know, just sometimes when people/ it doesn't matter what you sort of.. <i>do</i>, it's just a brick wall and that's where I was at, I was just keeping myself/ 'cause as I'm saying y'know I was on my own with it erm <i>very</i> little support and I'd already experienced people saying I'm out of</p>	<p><i>Said quietly and seriously; no humour or flippancy.</i></p> <p>On her own. [Link to P 14:459/460]</p> <p>The other crises had finished (as a result of her husband's death). [<i>Paradox</i>]</p> <p>No longer fearing the 'phone calls. [<i>Said flippantly</i>, but this diminishes Harper's fear of her husband's threatening behaviour at the time.]</p> <p>Just getting on – '<i>as you do!</i>' [<i>Coping, getting on with things – as though there's nothing else for it. Denial? This is a phrase Harper repeats on a number of occasions throughout the interview.</i>]</p> <p>No linking it to how it was for her; not making any sense of it. Not being 'invited' to go there. [<i>A sense that Harper wanted others to recognise what she was unable to verbalise herself? Emphasis on 'most definitely'.</i>]</p> <p>Needing to 'off-load' [<i>but not recognising – or not wanting to recognise - that the main crisis was in fact her husband's death.</i>]</p> <p>She was at a '<i>brick wall</i>'. [Link to therapeutic insights later on].</p> <p>Had already experienced someone saying she was out of their depth with her. [<i>Fear of rejection? Too vulnerable? Keeping herself ... safe?</i>]</p>

<p>my depth with you. And so that was that sense of/ and, I guess, my way of coping since – this is a hindsight thing - I guess erm my way of coping in the marriage when it was difficult was, I can't let anyone know what's going on so I can't get close to anybody because then they would know what's going on, and so .. (<i>slowly</i>) I'll just keep it close to me, I'll just keep it tight [<i>I: In a box or sort of ..?</i>] Yeah, not close, yeah, just I can manage this, it will get/ my faith was <i>is</i> was very important to me and it's like, come on, I really hate this, God, sort this out, but .. I can't tell anybody else erm and I <i>couldn't</i> tell anybody else the full extent of what was going on and I guess because there's something about if you tell someone else then you've got to admit it to yourself .. and <i>it didn't didn't fit with who I was</i>.</p> <p><i>I: Okay, didn't fit with who you were, [H: No] your perception of yourself -</i></p> <p>H: - My perception of myself it just so didn't fit, and that's been one I guess one of the major <i>struggles</i>, y'know, how on earth can you have/ 'cause that sense that erm well, firstly being in an abusive relationship, y'know I was intelligent I was sensible y'know, no-one thought that that was happening.. erm .. and .. y'know I wasn't going to/ I didn't want to break that bubble for myself (<i>laughingly</i>) let alone admit it to anyone else.</p>	<p>Harper's way of coping.</p> <p>Don't let anyone get too close or they'll find out what's going on. [A sense of shame? Exposure? Too threatening?]</p> <p>Talked to God instead. Faith important to her.</p> <p>Asked God to sort it out. Really hates what's happening. Couldn't tell anyone else – <i>emphasis on 'couldn't'</i> illustrates her feelings.</p> <p>If you tell someone else, you have to admit it to yourself. [Profound realisation here - in retrospect - of Harper's denial – about the marriage itself and the nature of her husband's death.] It didn't fit with who she was. [Very significant in terms of Harper's perception of herself at that time. P21/22:688-690]</p> <p>Major struggle to reconcile being in an abusive relationship to who she perceived herself to be. [<i>Emphasis on 'struggles'</i> illustrates how difficult this has been]. Questioning herself.</p> <p>Keeping it quiet.</p> <p>Didn't want to admit it to herself let alone anyone else. [The flippancy with which this is said belies the feelings Harper experienced at the time when she was in denial.] [What would be the consequences if that bubble did break?]</p>
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APPENDIX 20 (Table 9) Emerging themes: Extract 1	Original Transcript (Harper) Pages 5-8 lines 126-249	Initial coding: Extract 1
Structures time frame using temporal markers.	<p><i>You mentioned that 2003 was y'know a significant time [H: Mmm] - d'you want to tell me a little bit about your experience of ...</i></p> <p>H: ... of the bereavement. I'm going to have to go back a <i>little</i> bit because otherwise it won't make much sense at all ...</p> <p><i>I: That's fine, you just tell it as it is to you.</i></p> <p>H: So got married in '92 and come/ I would say my my youngest child was born in 97'. Erm, myself and my husband we were married over in Spain, he was Spanish speaking, had been an addict, erm and I'd met him in the drugs and alcohol and everything rehabilitation centre. I'd gone out there with the express desire that I would not meet <i>any</i> bloke over there because that was a very silly thing to do, but erm he'd been/ it was a Christian organisation, he'd been teaching, preaching, been clean for 5 years when I knew him. Erm we got married erm, and erm, so got married in '92, summer of '92, had my daughter in erm July of '94 – yeah – then I fell pregnant with my middle child, my son, my first son and he was born in the September '95. Before that we actually decided to actually leave the community setting where we were both working and come back to ----- because that's</p>	Contextualising narrative in a chronological format. Factual information conveyed. Husband had been an addict. Had gone to Spain with 'express desire' of not meeting ' <i>any</i> bloke' as this was ' <i>a very silly thing to do</i> '. [Why? Hint of a judgemental voice here? Or someone else's judgemental voice? Influence of past experience?] Describes where they met and what he did – and fact that husband 'clean' for 5years. [Was this important to Harper? How significant was the fact that it was a Christian organisation?] A sense of struggling to be specific about dates – hesitant repetitions of 'erm' .

<p>Starting from scratch. Harper as someone who always 'copes'; assuming responsibility.</p> <p>Time of transition.</p> <p>Harper as parent; 'my children'.</p> <p>Tensions in marriage; became more abusive.</p>	<p>where I had family, he/he had estranged family in Spain. So I came back, well we both came back, so I came back, married with one child and one about to be born. Erm my husband <i>spoke no English</i> and we were sort of starting off from from zero really, I had my parents, but when we came over we had to find a house to rent and furnish it and everything else as well as being sort of seven eight months pregnant and <i>I was the only one who could speak the language</i>. But, that transition went okay erm and then (<i>slowing down</i>) erm, had our last child in '97 August of '97 (<i>takes a deep breath</i>) and I think my husband was getting a bit <i>bored</i> with family life 'cos I was a bit busy with three children in three years and he/he was a bit of a male, bit of a male, (<i>laughs</i>) bit of a male Spaniard and the children <i>were</i> really <i>mine</i>, erm he tried his best, but they were <i>predominantly my children</i> (<i>quickly</i>) he wanted them, but I think he found that they took up quite a lot of time <i>as you might imagine</i> with three under/ well, a daughter who was three and two months when the third one was born, so yeah, they are quite demanding. Erm he'd made some friends erm he'd been to ESOL classes and he'd done some voluntary work within the church so he'd/he'd made some friends but, one or two were Spanish speaking but not all of them and he began to (<i>slowing down a bit</i>) secretly smoking and just/ the marriage just got/ there was tensions in it and he began to drink a bit more and go out and so it it/</p>	<p>Interesting change from 'I' to 'we' to 'I'.</p> <p>Returned to UK and faced with prospect of setting up new home. Husband spoke no English. (Repeated below) Starting off from zero, had to find and furnish a house, Harper 7-8 months pregnant and with one other young child, only one who could speak the language. Use of 'only' emphasises this point – [and this responsibility? A marked change from the person who went out to Spain with no intention of meeting a man.]</p> <p>A sense of it being a big transition, but one that went okay. [Harper as someone who always copes?] (P.3 lines 133-157) A sense here of Harper encountering difficult terrain as evidenced by her deep intake of breath and the slowing down of her narrative. The phrase 'a bit busy ...' underestimates the demands three young children were making on her. Said ironically. Slight shift in narrative tone here. The word 'bored' implies an understatement and has a slightly sarcastic nuance. [Is there an underlying feeling here of being let down – or rejected?] Refers in line 163 to the cultural difference that might have existed – 'bit of a male Spaniard'. Describes the children as 'predominantly my children', though quickly justifies that her husband wanted them too. [Is she justifying that to herself? What might it mean to Harper that they are her children? Was husband self-excluding from family unit or did H exclude him in some way] Phrase 'you might imagine' is said rhetorically and somewhat ironically.</p> <p>Describes the worsening tensions in the marriage and her husband's</p>
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<p>Fear.</p> <p>Petrified.</p> <p>Denial that this wasn't normal.</p> <p>Planning how to escape. Logical. Rational. 'In her head'.</p> <p>Real sense of fear. Married for life.</p> <p>Didn't want to be divorced.</p> <p>Temporal markers.</p> <p>Harper as 'coper'; keeping it all together – because</p>	<p>looking back it became more abusive than it had been before, and got to the point where (<i>pause</i>) erm - not at the time I wasn't aware of it - got to the point where I was very aware that I was petrified of him and/ but hadn't quite equated that that wasn't quite normal.. used to erm wake sort of in the evening when all three kids were in bed and he was out probably at a friend's erm often with the car, I knew he was drinking he'd been drinking before he left so he was drunk all the time erm and it was like crumbs how do I get these/ and I would go through this sort of (<i>matter-of-factly</i>) how do I get these three kids out of this house if he comes back and is abusive, (<i>intake of breath</i>) and I just ...</p> <p><i>I: (Questioningly) Sense of/ a real sense of fear..?</i></p> <p>A real sense of fear, but that's only with hindsight. [<i>I: Okay</i>] I knew I was thinking it at the time but it was just like well, you've got to stay, I didn't want to get <i>divorced</i>, I'd married for life and that was very much a big thing for me.. erm, and .. once or twice I (<i>pause</i>) I'd wondered whether he'd taken anything else other than just drink erm, but had no proof/ I'd seen him/he'd told me the Christmas of 2002, no Christmas 2001 he'd told me that erm he was going to leave for another woman, but could we have Christmas together.. I spoke to a friend and yes, okay (<i>sighs</i>) we'll keep it all together, and we did (<i>intake of breath and sigh</i>) because that's what I did (<i>self-deprecating</i>) and he never did go but he was all over the</p>	<p>gradual withdrawal from [<i>rejection of?</i>] the family. Slows down when describing his secret smoking and drinking. Use of 'just' emphasises Harper's struggle to explain this difficult period. Use of 'the' as opposed to 'my' or 'our' marriage objectifies the relationship and distances H's role in it.</p> <p>With hindsight, gradual awareness that relationship had become more abusive – 'looking back ...' Explains that not aware of this at that time as signalled by the pause in line 177, but reaches the point where 'very aware' that she was 'petrified' of him. Not aware that this wasn't 'quite normal'. [<i>In denial? Aware versus unaware? Confusion?</i>]</p> <p>Spent time planning how to escape – but husband would often take the car so no means of escape there.</p> <p>Going over in her mind how she would get 'these three kids out of this house' if he came back and was abusive. Use of pronouns 'these' and 'this' emphasises specificity of intention. Fear evident in her intake of breath which contrasts strongly with the matter-of-fact way she describes these feelings. [<i>Is this Harper's way of dealing with the fear she feels? Also her instinct as a mother to protect her children</i>].</p> <p>Tails off .. [too difficult to complete sentence?]</p> <p>Describes her real sense of fear – but in hindsight.</p> <p>Didn't want to get divorced. Emphasis on 'divorced'.</p> <p>Had married for life and this was very important to her. [<i>Did this conflict with her desire to leave the abusive relationship and therefore conflict with her perception of herself? She hadn't wanted to parent on her own – see lines 26/27. Also a conflict with religious beliefs?</i>]</p> <p>Change in direction here. The pause signals an important shift in the narrative and Harper's intonation changes and slows.</p> <p>Describes wondering (suspecting?) that husband was taking drugs. Prefaces this by saying that husband wanted to leave for another woman, but could they have Christmas together.</p> <p>Harper very resigned here, <i>sighs deeply</i> and describes how she agreed to her husband's wishes 'because that's what I did'. [<i>Did she have another choice? What did she want at that time? A sense that maybe she put her own needs last? What does the phrase 'that's what</i></p>
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<p>that's what she did.</p> <p>Suffering verbal abuse; fear of abuse escalating and becoming physical.</p> <p>Body gives up – massive panic attack.</p> <p>Medication to help her to cope.</p>	<p>place, so all over the place, quite abusive in front of the children, but it was always on a verbal/ on a yep on a verbal level never/ I was always concerned that he would (<i>gives each word equal emphasis</i>) physically assault me <i>but he never did physically assault me</i> whilst we were still living together .. and so it got to sort of June time and I/ I think my body had just given up so I had a massive panic attack and went to A&E and then came home and spent the weekend and he/ [I] spent the weekend <i>absolutely shattered</i> by which time my parents/ my parents weren't aware of where the marriage was at, but my dad had taken me to A&E so I guess he knew that something wasn't quite right, but didn't know why erm and my husband during that weekend kept on blaming me that it was all in my head that I was making it all up blah-de-blah-de-blah so I started counselling and ended up on <i>very mild</i> anti-depressants erm just to cope really and erm discussed with my husband that he really needed to get his alcohol problem sorted out, so he went off to a well, went off .. I'd refused to go on holiday with him and the children, it was like no, you mucked up last year, you were drunk and everything , it's like no, I'm not going, so my parents invited us to go away with them and the agreement was that during the August when we were away for a fortnight that my husband would stay at home and then he would take himself off to a rehabilitation centre that er, (<i>pause</i>) was actually in --</p>	<p>I did' imply about Harper's patterns of behaviour? Sounds like she always did what was asked of her.]</p> <p>Describes the escalation of her husband's abusive behaviour.</p> <p>Repetition of 'all over the place, so all over the place' indicates how chaotic he was. Also in front of the children. [A crossing of a line here in terms of the level of abuse – and an increase in Harper's fear for her personal safety?]</p> <p>Describes the verbal abuse.</p> <p>Describes her continued concern that he would assault her physically, and emphasises each word.</p> <p>[Is there a sense that 'concerned' somehow diminishes the fear Harper is feeling here?]</p> <p>Body had given up; massive panic attack; absolutely shattered. [Couldn't hold it in any longer?]</p> <p>Parents not aware of seriousness of situation.</p> <p>Husband kept blaming H.</p> <p>H put on mild anti-depressants. [Emphasis on 'very mild' – is this because she saw it as a weakness? Wanted to 'cope' at all costs.]</p> <p>Husband agreed to sort out his alcohol problem.</p> <p>Harper being assertive and refusing to go away with him.</p>
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<p>Temporal markers.</p> <p>Fear and panic.</p> <p>Decision to leave</p>	<p>--- erm, and it was a Christian one and the leader spoke Spanish and he would take himself off whilst we were away. I 'phoned up a couple of days before we were coming back and he still hadn't gone, and it was like you <i>need</i> to go. Er, so erm he <i>did</i> go so by the time we came back off holiday he'd <i>gone</i>. And.. then <i>..(thinking)</i> it must have been two weeks in, so we were coming up to being able to have a visit it was my son's/ would have been my son's 7th birthday and our 10th wedding anniversary on the 6th September, but on the 5th/ so the kids had just gone back to school, they were 5, 7 and 8 well, ----- was nearly 7, the day before his birthday, and ----- had just turned 5, and er got a 'phone call just as I'd come back home from dropping the kids off at school saying .. this was from the Spanish speaking person ..he says, your husband's really kicked off erm last night erm we've kept him overnight but he's going, he's coming home, it was like, oh! what am I going to do? So at that point I took our passports because I was concerned that he would take the kids and erm made my mind up that I was leaving ..</p>	<p>Anxiety that husband hadn't gone to the centre. [Emphasis on 'need' reflects Harper's anxiety – and also her hope??]</p> <p>Importance of temporal markers here. [Harper thinks carefully to make sure she is accurate]. Significant dates: wedding anniversary; son's birthday; being able to have a visit. [What were Harper's hopes at this point?]</p> <p>Fear at receiving this unexpected 'phone call. Panic?</p> <p>Decided 'at that point' [realising that things had gone too far?] to take their passports and made up mind to leave.</p>
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APPENDIX 21 (Table 10) Emerging themes	Original Transcript (Harper) (Pages 20-22 lines 646-700)	Initial coding: Extract 2
<p>On my own. Alone.</p> <p>Sense of relief from the fear.</p> <p>Coping. Managing. Getting on with things.</p> <p>Not making any sense of it for herself. Not linking it. Denial. Wanting to be 'invited' to.</p>	<p>(Page 20:646) ...I had a bit of support at different points but predominantly it was, (<i>quietly</i>) well, it was me .. on my own.</p> <p><i>I: (Reflecting empathically) You on your own.</i></p> <p>H: Yep. Yes, that's how it was. Erm .. so .. I was still seeing the counsellor weekly 'cause I'd got a bit more/ bit/ different crisis .. in some ways some of the other crises had finished because at least I wasn't wondering about what would happen and would he be there and whether I'd have a 'phone call or anything like that , so .. we just got on ..(<i>flippantly</i>) <i>as you do!</i></p> <p><i>I: How were you making any sense of it, of what had happened? – For you?</i></p> <p>H: I <i>didn't</i> at that point. I didn't make any sense erm (<i>pause</i>) no, I don't think there was any linking it to how how is this for <i>me</i>.. no-one was <i>inviting</i> me to go there, most definitely, there wasn't –</p> <p><i>I: Not even the counsellor?</i></p> <p>H: Well, I was very/ I was going to see/ I was still going to see her 'cause I <i>had</i> to see her, [<i>I: Yes</i>] it wasn't <i>her</i></p>	<p>Said quietly and seriously; no humour or flippancy.</p> <p>On her own. [Link to P 14:459/460]</p> <p>The other crises had finished (as a result of her husband's death). [<i>Paradox</i>]</p> <p>No longer fearing him turning up or fearing the 'phone calls. [<i>Said flippantly</i>, but this diminishes Harper's fear of her husband's threatening behaviour at the time.]</p> <p>Just getting on – '<i>as you do!</i>' [<i>Coping, getting on with things – as though there's nothing else for it. Denial? This is a phrase Harper repeats on a number of occasions throughout the interview.</i>]</p> <p>No linking it to how it was for her; not making any sense of it.</p> <p>Not being 'invited' to go there. [A sense that Harper wanted others to recognise what she was unable to verbalise herself? <i>Emphasis on 'most definitely'.</i>]</p> <p>Needing to 'off-load' [<i>but not recognising – or not wanting to recognise - that the main crisis was in</i></p>

<p>Unable to access her feelings. Numb.</p> <p>A brick wall.</p> <p>Very little support. Experience of rejection by previous counsellor.</p> <p>Way of coping in marriage – a pattern.</p> <p>Can't let anyone in. Denial.</p> <p>Keep things hidden.</p> <p>Trust in God.</p> <p>Denial of the truth to</p>	<p>making me go / knew I needed to off-load so I was very much in off-load mode, it was like, yeah, this is happening, and I just couldn't go anywhere with anything y'know so yeah, I'm sure (<i>laughs</i>) I'm sure she sort of/ .. she she was fab counsellor, but, y'know, just sometimes when people/ it doesn't matter what you sort of.. <i>do</i>, it's just a brick wall and that's where I was at, I was just keeping myself/ 'cause as I'm saying y'know I was on my own with it erm very little support and I'd already experienced people saying I'm out of my depth with you. And so that was that sense of/ and, I guess, my way of coping since – this is a hindsight thing - I guess erm my way of coping in the marriage when it was difficult was, I can't let anyone know what's going on so I can't get close to anybody because then they would know what's going on, and so .. (<i>slowly</i>) I'll just keep it close to me, I'll just keep it tight [<i>! In a box or sort of ..?</i>] Yeah, not close, yeah, just I can manage this, it will get/ my faith was <i>is</i> was very important to me and it's like, come on, I really hate this, God, sort this out, but .. I can't tell anybody else erm and I <i>couldn't</i> tell anybody else the full extent of</p>	<p>fact her husband's death].</p> <p>Knew it was happening but couldn't go anywhere with anything. [Anything emotional or to do with her grief.]</p> <p>She was at a 'brick wall'. [Link to therapeutic insights later on].</p> <p>On my own. Very little support. Had already experienced someone saying she was out of their depth with her. [Fear of rejection? Too vulnerable? Keeping herself ... safe?]</p> <p>Harper's way of coping. [In retrospect].</p> <p>Don't let anyone get too close or they'll find out what's going on. [A sense of shame? Exposure? Didn't feel acceptable?]</p> <p>Talked to God instead. Faith important to her.</p> <p>Asked God to sort it out. Really hates what's happening.</p> <p>Couldn't tell anyone else – emphasis on 'couldn't'</p>
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<p>herself.</p> <p>Not fitting with who she is.</p> <p>Didn't fit with perception of self. Major struggle to accept the reality.</p> <p>Incongruence between the reality and her sense of self. Denial.</p> <p>Admitting the truth to someone else would mean admitting it to herself; would 'break the bubble'.</p>	<p>what was going on and I guess because there's something about if you tell someone else then you've got to admit it to yourself .. and it didn't <i>didn't</i> fit with who I was.</p> <p><i>I: Okay, didn't fit with who you were, [H: No] your perception of yourself -</i></p> <p>H: - My perception of myself it just <i>so</i> didn't fit, and that's been one I guess one of the major <i>struggles</i>, y'know, how on earth can you have/ 'cause that sense that erm well, firstly being in an abusive relationship, y'know I was intelligent I was sensible y'know, no-one thought that that was happening.. erm .. and .. y'know I wasn't going to/ I didn't want to break that bubble for myself (<i>laughingly</i>) let alone admit it to anyone else.</p>	<p>illustrates her feelings.</p> <p>If you tell someone else, you have to admit it to yourself. [Profound realisation here - in retrospect - of Harper's denial – about the marriage itself and the nature of her husband's death.] It didn't fit with who she was. [Very significant in terms of Harper's perception of herself at that time. P21/22:688-690]</p> <p>Major struggle to reconcile being in an abusive relationship to who she perceived herself to be. [Emphasis on 'so' and 'struggles' illustrates how difficult this has been].</p> <p>Questioning herself.</p> <p>Keeping it quiet.</p> <p>Didn't want to admit it to herself let alone anyone else. [The flippancy with which this is said belies the feelings Harper experienced at the time when she was in denial.] [What would be the consequences if that bubble did break?]</p>
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APPENDIX 22 (Table 11) Original Transcript (Jessica)	Initial coding Pages 8-10: lines 241-326
<p>.. I lost my daughter, she was my second child, and then as well we later found out that we had been affected by the organ retention scandal, if you remember that that...</p> <p>I: Yes.</p> <p>J: We weren't in ----- at the time um so it wasn't ----- but it was ----- the same/ it it happened at um a lot of hospitals all round the country, so um it was that. Um if I give you just a little bit of a picture of the sort of just the run up, um late into my pregnancy we decided to spend a week with my parents in ----- and while we were there um I felt that things weren't quite right so I went to the local hospital to be checked out and, incidentally, it was the hospital where I'd had my first daughter, so I went there and they said that the baby's fine, I'm not about to go into labour, um but they felt it was advisable that I travel back that day, but there was no need to rush, so we did that, and we set off - I was driving because my husband hadn't, at that point, learnt to drive - and then in the middle of nowhere, we were <i>40 miles</i> away from home, I was driving and I went into labour [<i>laughs</i>] so er it was a nightmare. There were no/ there was no hard shoulder so I couldn't stop, there were no public 'phones, there were no mobile 'phones in those days and I had no choice but to keep on driving with regular full on contractions and, including the baby, I had four lives in my hands and that was a nightmare [<i>laughs</i>]. I don't know if you've had children?.</p> <p>I: <i>I haven't got children actually ...</i></p> <p>J: But you can sort of appreciate that...</p>	<p>Describes briefly that she lost second child – a daughter. Intensely personal but also a widely publicised medical scandal</p> <p>Provides chronological context and period of time leading up to the birth.</p> <p>Felt things weren't 'quite right'.</p> <p>Hospital staff seemed to be reassuring, baby fine, but advised to travel home.</p> <p>Jessica driving [so responsible for getting family home]</p> <p>In the middle of nowhere, she goes into labour. [Emphasis on '40 miles away from home' also suggests a race against time].</p> <p>A <i>nightmare</i>; no hard shoulder; no public phones, no mobile phones. Repetition of 'no' emphasises the sense of isolation and panic. [What is going through Jessica's mind at this moment? Extract has surreal quality to it that characterises some nightmares – 'in the middle of nowhere'].</p> <p>No choice but to keep driving with regular full-on contractions; four lives in her hands. Repetition of 'nightmare' emphasises the horror of the situation and the tremendous responsibility for Jessica.</p>

<p><i>I: That was for you, well...</i></p> <p>J: Mmm, but but you can appreciate that labour is a really sort of/ they don't call it labour for nothing and to be driving and in the middle of nowhere it was <i>horrendous</i>. Um at the hospital I um I was settled in and then things progressed and later I was told that your baby's in distress and I had to have an emergency Caesarian section to deliver her with a general anaesthetic, and I don't come out of anaesthetics very well and I was very, very drowsy and I just became aware of a voice saying 'You have a little girl, and I'm sorry but she's not very well' and I <i>heard</i> it but I wasn't really with it to take in the enormity of that and then probably a couple of hours later another voice dropping this bombshell and I was <i>still</i> very drowsy and they said that 'Your baby's on a life support machine and I'm sorry, we've done all that we can and we think it would be for the best to switch off the life support and we need your permission to turn it off'. So I was there, really drowsy, I <i>couldn't</i> really talk, I couldn't think, and I was being asked to switch off my baby's life support, so I/ I mean at the time, and looking back, I remember just feeling desperate that I was desperate not to give up on my child, er she was probably at that stage, about two hours old, I was still drowsy but I just <i>knew</i> I didn't want to, I was <i>desperate</i> not to give up on her and I was frantically trying, you know, words going round in my head but I couldn't get them out of my mouth, but I must have managed to have said no because they then said to me that it's kinder to let her die with dignity and I just felt completely squashed at that point, my wishes were squashed and they switched off the machine and she died in my arms. So that was my bereavements.</p>	<p>Infers that her labour was intensely painful. Describes it as a '<i>horrendous</i>' experience to be driving and '<i>in the middle of nowhere</i>' (repeated again).</p> <p>Settled in then told baby in distress and she would need emergency Caesarian section under general anaesthetic.</p> <p>Doesn't come out of anaesthetic well. '<i>Very, very drowsy</i>'. [In another world? Not capable of making a decision of such magnitude. Didn't medical staff realise this?]</p> <p>Aware of voice saying her little girl not very well.</p> <p>Heard voice but didn't take in enormity of what was said.</p> <p>Another voice '<i>dropping this bombshell</i>'. [A powerful metaphor which presages the devastating consequences to follow.]</p> <p>Baby on life support, they've done all they can, and Jessica being asked permission to switch it off.</p> <p>Emphasis of <i>really really drowsy; couldn't talk; couldn't think</i>. [A dreadful situation. Continues the nightmarish quality from the previous extract. Unimaginable.]</p> <p>Jessica feeling '<i>desperate</i>' (repeated) not to give up on her child. '<i>Knew</i>' she didn't want to.</p> <p>Drowsy, but desperate and frantically trying to get the words out. [A strong sense of the frantic desperation here and the horror of the situation – a continuing nightmare].</p> <p>Words going around in her head and couldn't get them out of her mouth – frantic.</p> <p>Managed somehow to say 'no, but persuaded to agree. [Not heard]</p> <p>'<i>Felt completely squashed</i>', her wishes were squashed. [Like a fly having the life squashed out of it underfoot. No strength to fight back.]</p>
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<p><i>I: So sad.</i></p> <p>J: Yep, and then um three weeks after she died, we'd gone back to the hospital to um get results of, I don't know if it was the post mortem or just what they had um/ tests that <i>they</i> had done in the hospital and they said to us that/ the um paediatrician said that there was an operation that she <i>could</i> have had but it only had a small chance of success, so I was absolutely <i>stunned</i> because what I was hearing was that there <i>was</i> a chance that she could have survived and she had been denied that and I'm hearing that three weeks after she's dead. So I had to get my head round not only the loss of my little girl, but being pressurised for switching off her life support and on top of that knowing that there <i>was</i> a chance she could have survived, so that just <i>added</i> to it. Um so I had to get my head round all of that, but I didn't. Um initially it just felt too harrowing, I tried to suppress my feelings and as well I felt, because my first daughter, she was 21 months old, that's still really a baby, and I felt that I had to carry on for her so I was trying to carry on as if everything was normal but of course everything had changed.</p>	<p>Machine switched off and daughter died in Jessica's arms. [An unimaginable experience.]</p> <p>Went to get results of post-mortem only to be told that there was an operation her daughter could have had which might have had a small chance of success.</p> <p>Jessica '<i>absolutely stunned</i>' by this news.</p> <p>Daughter could have had a chance, but denied this.</p> <p>Had to get her head around losing her little girl and being forced to turn off her life support.</p> <p>Knowing there was a chance she could have survived just <i>added</i> to it. Emphasis on '<i>added</i>' and '<i>was</i>'.</p> <p>Couldn't get her head round it. '<i>Just felt too harrowing</i>'. Tried to suppress feelings as too painful and also for sake of other child.</p> <p>Tried to carry on as normal but '<i>everything had changed</i>'. [Jessica's whole life had been turned upside down.]</p>
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APPENDIX 23 (Table 12) Emerging themes	Original Transcript (Jessica) Pages 8-10: lines 241-326	Initial coding
<p>Organ retention scandal.</p> <p>Personal and public dimensions.</p> <p>Anxiety</p> <p>Sense of responsibility</p> <p>Nightmare of going into labour.</p> <p>Panic.</p> <p>Fear.</p> <p>No choice.</p>	<p>I lost my daughter, she was my second child, and then as well we later found out that we had been affected by the organ retention scandal, if you remember that that...</p> <p>I: Yes.</p> <p>J: We weren't in ----- at the time um so it wasn't ----- but it was ----- the same/ it it happened at um a lot of hospitals all around the country, so um it was that. Um if I give you just a little bit of a picture of the sort of just the run up, um late into my pregnancy we decided to spend a week with my parents in ----- and while we were there um I felt that things weren't quite right so I went there and they said that the baby's fine, I'm not about to go into labour, um but they felt it was advisable that I travel back that day, but there was no need to rush, so we did that, and we set off - I was driving because my husband hadn't, at that point, learnt to drive - and then in the middle of nowhere, we were <i>40 miles</i> away from home, I was driving and I went into labour [<i>laughs</i>] so er it was a nightmare. There were no/ there was no hard shoulder so I couldn't stop, there were no public 'phones, there were no mobile 'phones in those days and I had no choice but to keep on driving with regular full on contractions and, including the</p>	<p>Describes briefly that she lost second child – a daughter.</p> <p>Intensely personal but also a widely publicised medical scandal.</p> <p>Provides chronological context and period of time leading up to the birth.</p> <p>Felt things weren't 'quite right'.</p> <p>Hospital staff seemed to be reassuring, baby fine, but advised to travel home.</p> <p>Jessica driving [so responsible for getting family home]</p> <p>In the 'middle of nowhere', she goes into labour. <i>Emphasis on '40 miles away from home'.</i></p> <p>A 'nightmare'; no hard shoulder; no public phones, no mobile phones. Repetition of 'no' emphasises the sense of isolation and panic. [<i>What is going through Jessica's mind at this moment? Extract has surreal quality to it that characterises some nightmares – 'in the middle of nowhere'.</i>]</p> <p>No choice but to keep driving with regular full-on contractions; four lives in her hands.</p>

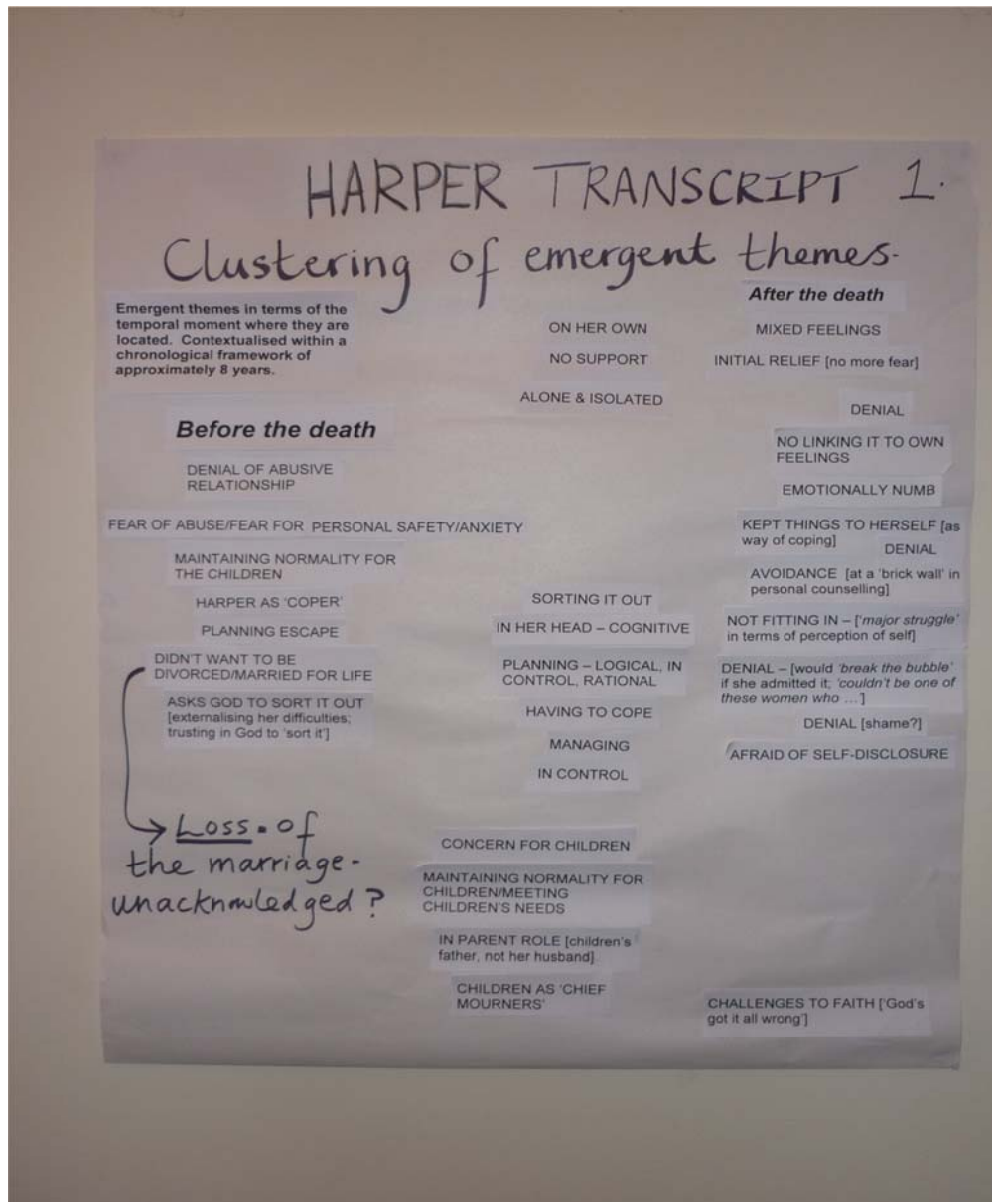
<p>Physical pain. Huge responsibility for family. Alone.</p> <p>Not taking in the enormity of what was being said</p> <p>'Dropping the bombshell'</p> <p>Unable to think or talk</p>	<p>baby, I had four lives in my hands and that was a nightmare [laughs]. I don't know if you've had children?.</p> <p>I: I haven't got er children actually, for various reasons, but...</p> <p>J: But you can sort of appreciate that...</p> <p>I: That was for you, well...</p> <p>J: Mmm, but but you can appreciate that labour is a really sort of/ they don't call it labour for nothing and to be driving and in the middle of nowhere it was <i>horrendous</i>. Um at the hospital I um I was settled in and then things progressed and later I was told that your baby's in distress and I had to have an emergency Caesarian section to deliver her with a general anaesthetic, and I don't come out of anaesthetics very well and I was very, very drowsy and I just became aware of a voice saying 'You have a little girl, and I'm sorry but she's not very well' and I <i>heard</i> it but I wasn't really with it to take in the enormity of that and then probably a couple of hours later another voice <i>dropping this bombshell</i> and I was <i>still</i> very drowsy and they said that 'Your baby's on a life support machine and I'm sorry, we've done all that we can and we think it would be for the best to switch off the life support and we need your permission to turn it off'. So I was there, really drowsy, I <i>couldn't</i> really talk, I couldn't think, and I was being asked to switch off my baby's life support, so I/ I mean at the time, and looking back, I remember just feeling <i>desperate</i> that I was <i>desperate</i> not to give up on my child, er she was</p>	<p>Repetition of 'nightmare' emphasises the horror of the situation and the tremendous responsibility for Jessica.</p> <p>Infers that her labour was intensely painful. Describes it as a 'horrendous' to be driving and in the 'middle of nowhere' (repeated again).</p> <p>Settled in at the hospital, then told baby in distress and she would need emergency Caesarian section under general anaesthetic.</p> <p>Doesn't come out of anaesthetics well. 'Very, very drowsy'. [In another world? Not capable of making a decision of such magnitude. Didn't medical staff realise this?]</p> <p>Aware of voice saying her little girl not very well. 'Heard' (emphasised) voice but didn't take in enormity of what was said.</p> <p>Another voice 'dropping this bombshell'. A powerful metaphor which presages the devastation to come. 'Still very drowsy' emphasises Jessica's reduced mental capacity at the time.</p> <p>Baby on life support, they've done all they can, and Jessica being asked permission to switch it off. [Almost incomprehensible in terms of the implications].</p> <p>Emphasis of 'really really drowsy'; couldn't talk; couldn't think reinforces the nightmarish quality of the previous extract.</p> <p>Jessica feeling 'desperate' (repeated and emphasised) not to give up on her child. 'Knew' she didn't want to. [A continuing</p>
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<p>Desperation</p> <p>NO WORDS NO VOICE</p> <p>Completely squashed NOT HEARD POWERLESSNESS</p> <p>Stunned</p> <p>Incomprehensible</p>	<p>probably at that stage, about two hours old, I was still drowsy but I just <i>knew</i> I didn't want to, I was <i>desperate</i> not to give up on her and I was frantically trying, you know, words going round in my head but I couldn't get them out of my mouth, but I must have managed to have said no because they then said to me that it's kinder to let her die with dignity and I just felt completely squashed at that point, my wishes were squashed and they switched off the machine and she died in my arms. So that was my bereavements.</p> <p>I: So sad.</p> <p>J: Yep, and then um three weeks after she died, we'd gone back to the hospital to um get results of, I don't know if it was the post mortem or just what they had um/ tests that <i>they</i> had done in the hospital and they said to us that/ the um paediatrician said that there was an operation that she <i>could</i> have had but it only had a small chance of success, so I was <i>absolutely stunned</i> because what I was hearing was that there was a chance that she could have survived and she had been denied that and I'm hearing that three weeks after she's dead. So I had to get my head round not only the loss of my little girl, but being pressurised for switching off her life support and on top of that knowing that there was a chance she could have survived, so that just <i>added</i> to it. Um so I had to get my head round all of that, but I didn't. Um initially it just felt too harrowing, I tried to suppress my feelings and as well I</p>	<p>nightmare.]</p> <p>'Still drowsy', but <i>desperate</i> and frantically trying to get the words out. A strong sense of the frantic desperation here [and the horror of the situation and Jessica's aloneness].</p> <p>Words going around in her head and couldn't get them out of her mouth – frantic. Managed somehow to say 'no', but persuaded to agree. [Not heard; a sense of 'emotional coercion' here?]</p> <p>'Felt completely squashed', her wishes were squashed. [Like a fly having the life squashed out of it underfoot. No strength to fight back.] Machine switched off and daughter died in Jessica's arms. [An unimaginable experience.]</p> <p>Went to get results of post-mortem only to be told that there was an operation her daughter could have had which might have had a small chance of success.</p> <p>Jessica '<i>absolutely stunned</i>' by this news.</p> <p>Daughter <i>could</i> have had a chance, but denied this.</p> <p>Had to get her head around not only losing her little girl, but also being '<i>pressurised</i>' to turn off her life support.</p> <p>Knowing there was a chance she could have survived just <i>added</i> to it. Emphasis on '<i>was</i>' and '<i>added</i>' exemplifies the enormity of the experience for Jessica.</p> <p>Wasn't able to get her head round it.</p>
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<p>Overwhelmed by her loss</p> <p>Suppressed feelings</p> <p>Tried to go on as normal</p> <p>Her assumptive world had been destroyed</p>	<p>felt, because my first daughter, she was 21 months old, that's still really a baby, and I felt that I had to carry on for her so I was trying to carry on as if everything was normal but of course everything had changed.</p>	<p>'Just felt too harrowing'.</p> <p>Tried to suppress feelings as too painful and also for sake of other child.</p> <p>Tried to carry on as normal but 'everything had changed'.</p> <p>[Jessica's whole life had been turned upside down. A traumatic experience.]</p>
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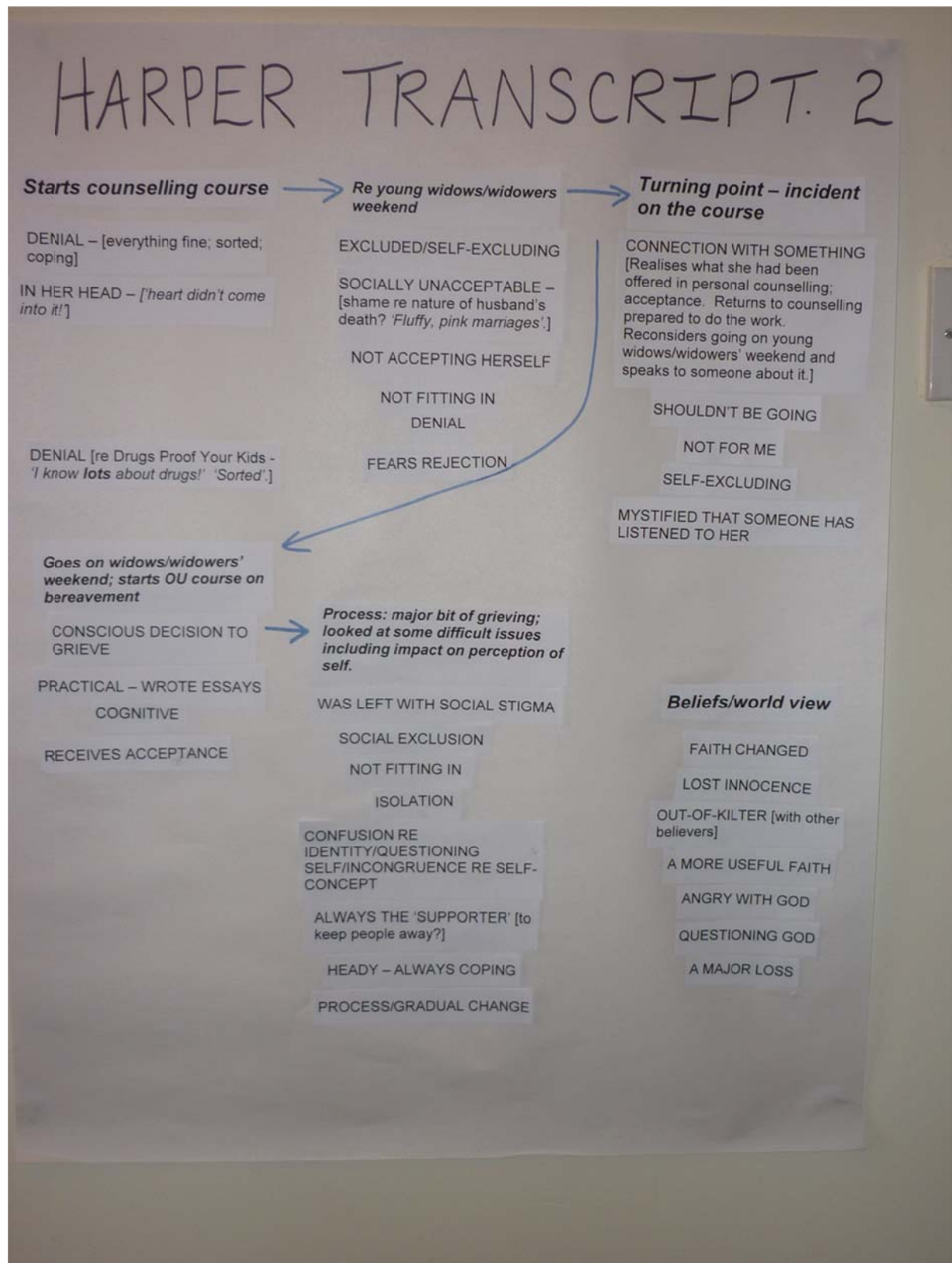
APPENDIX 24 (a)

Harper - Initial clustering of themes: temporal organisation



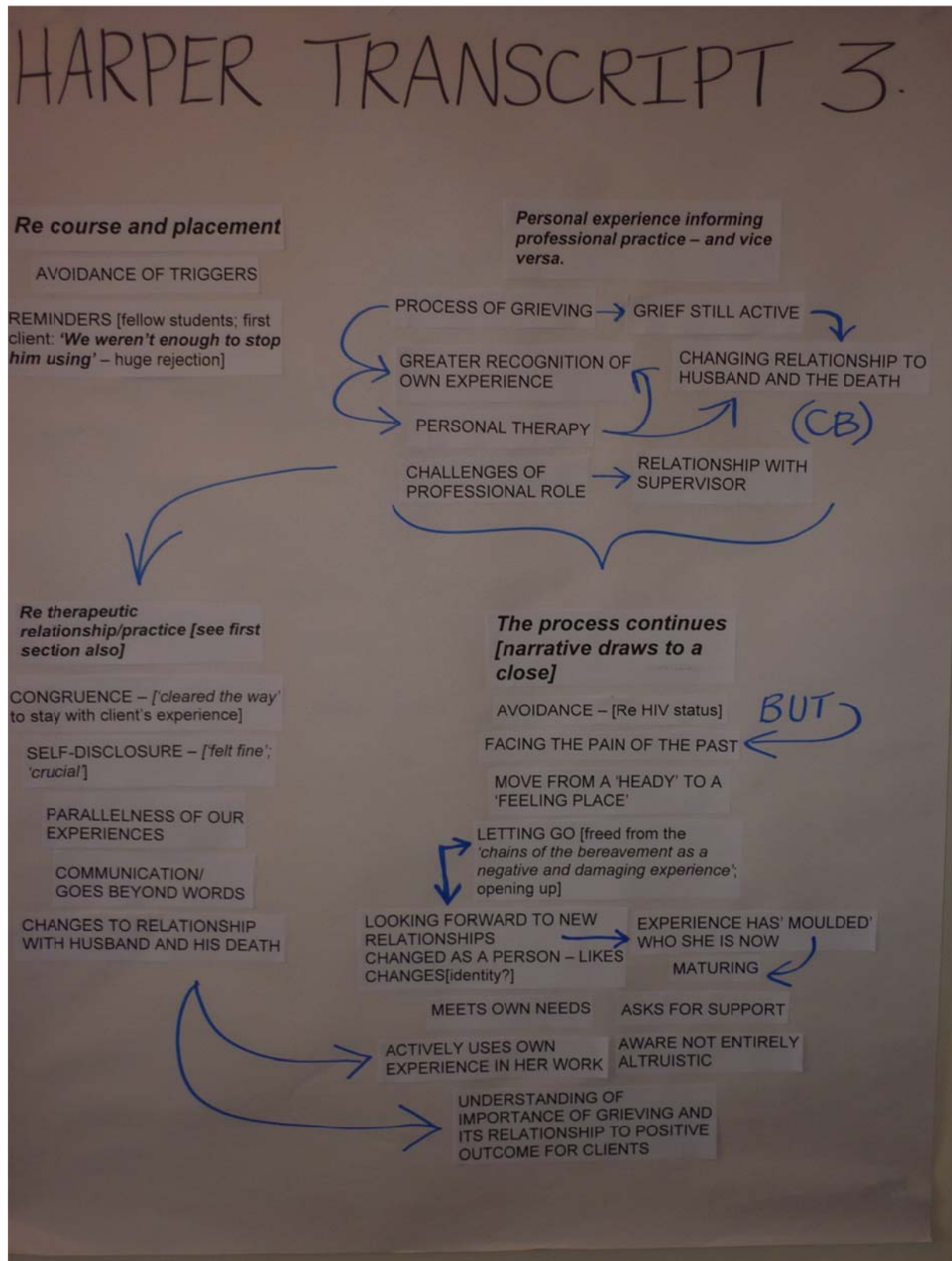
APPENDIX 24 (b)

Harper - Initial clustering of themes: temporal organisation



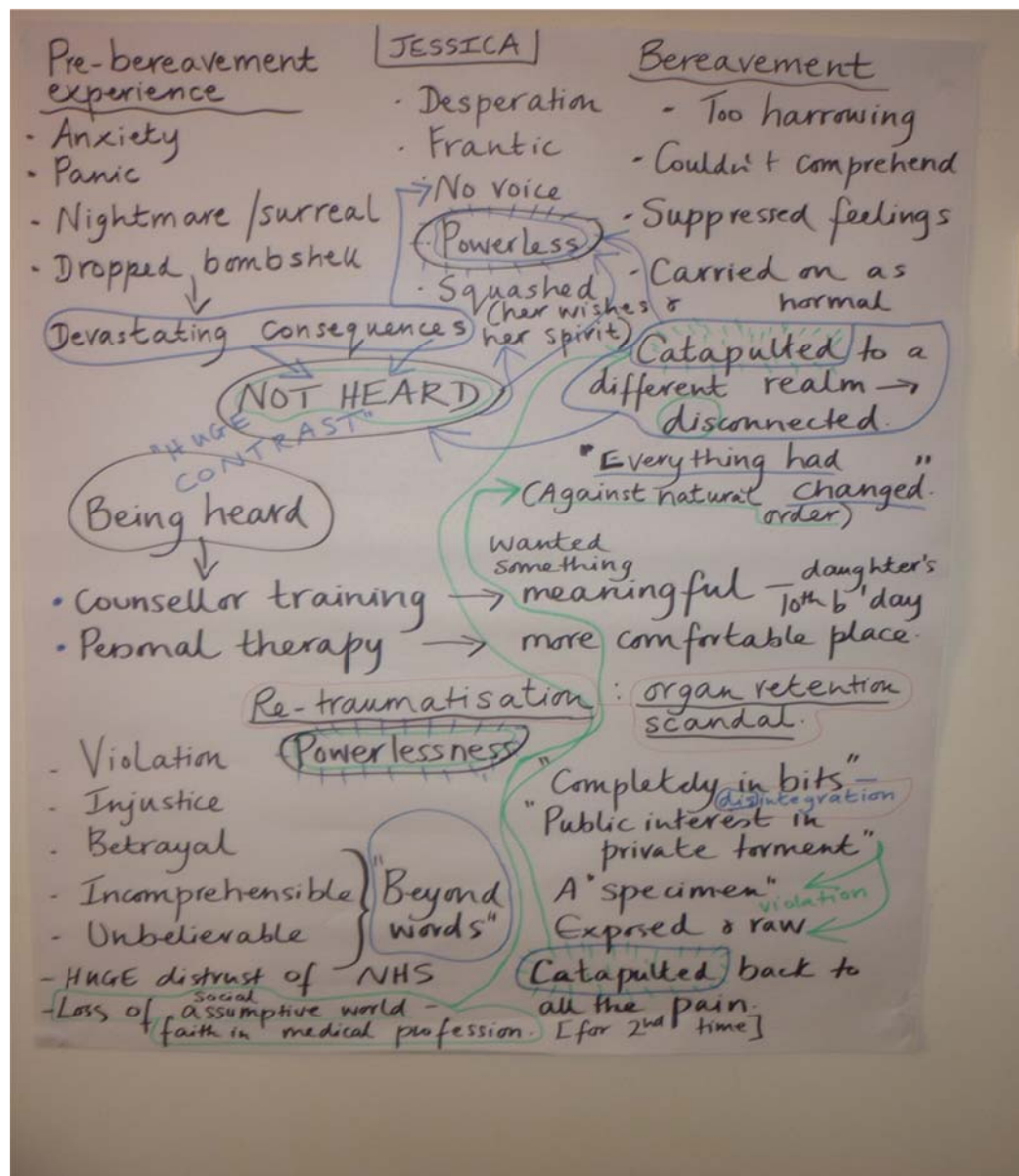
APPENDIX 24 (c)

Harper - Initial clustering of themes: temporal organisation



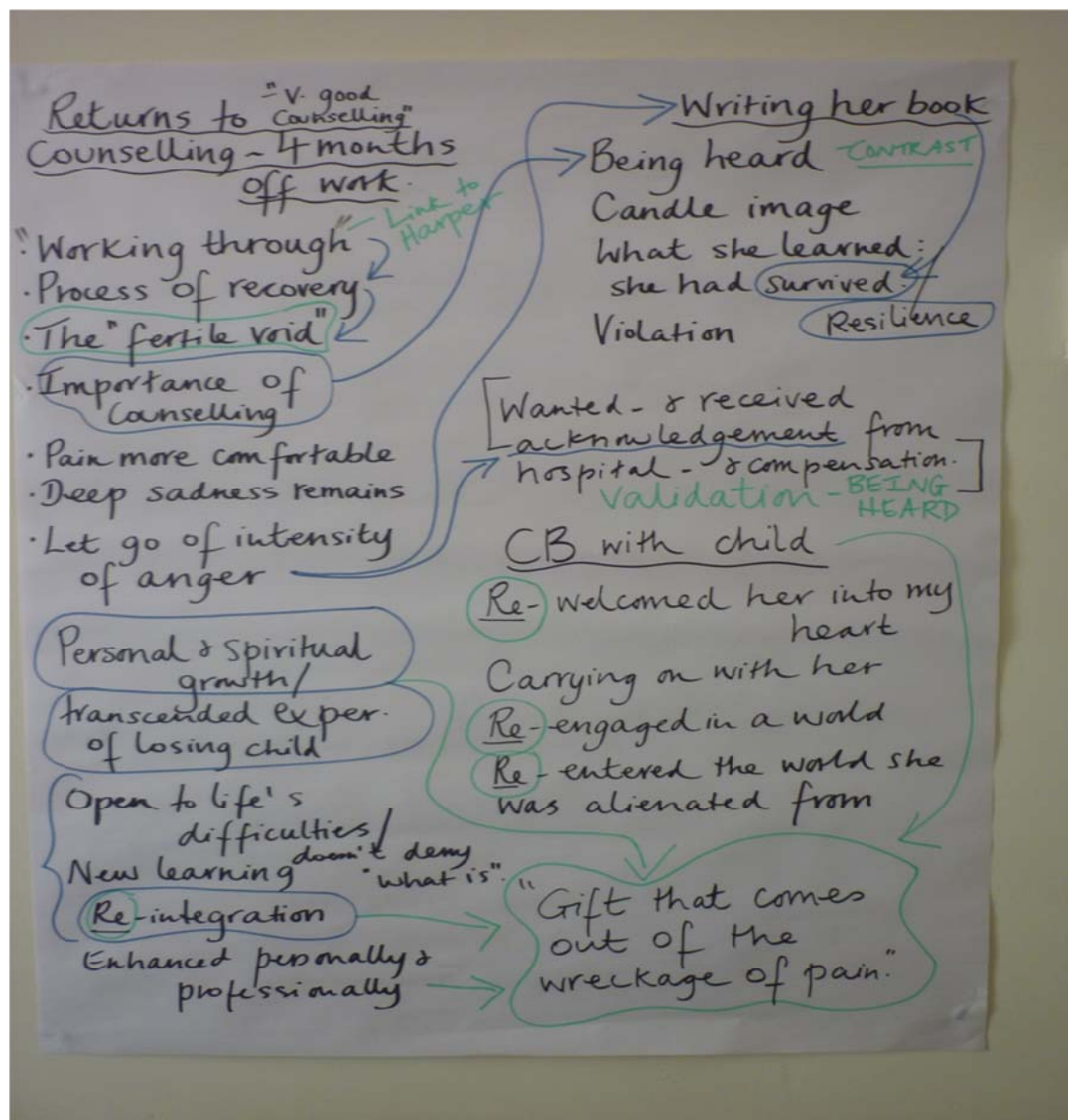
APPENDIX 25 (a)

Jessica - Initial clustering of themes



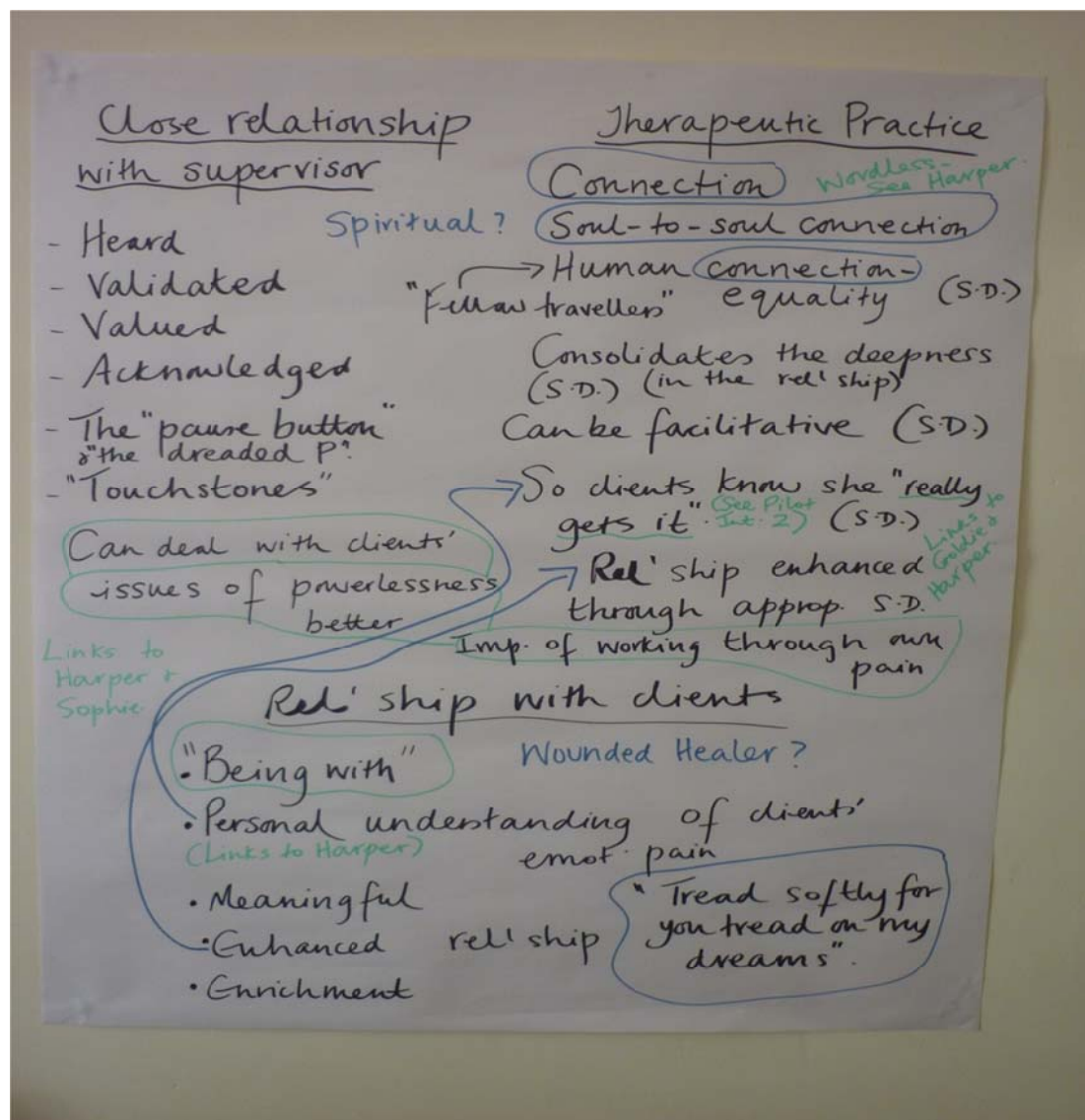
APPENDIX 25 (b)

Jessica - Initial clustering of themes



APPENDIX 25 (c)

Jessica - Initial clustering of themes



APPENDIX 26 Table 13

Goldie - Summary table of themes

	Cluster themes	In vivo quote	Page/line(s)
Super-ordinate theme 1: <i>'I miss her so much': The painful process of grieving</i>	<ul style="list-style-type: none"> - Anticipatory grief - Pining - Regret - Seeking a connection - Continuing bonds 	<p>She ceased in many ways to be the same person. And I <i>miss</i> her. So much. I'm still grieving for my mother.</p> <p>Never really felt I got to say goodbye.</p> <p>Strange though it sounds .. feels like a connection for me.</p> <p>There's a parallel with my mother <i>going</i> and me <i>taking on</i> more of the traits ...</p>	<p>3:82-84</p> <p>5:122; 150/1</p> <p>5:121</p> <p>5:130/1</p> <p>7:194/5</p>
Super-ordinate theme 2: <i>Existential questions and making sense</i>	<ul style="list-style-type: none"> - Questioning the world - Making sense - Identity 	<p>The world is changing .. feels sad and scary.</p> <p>It's the natural order of things .. it was expected .. it's a stage of life .. I guess I'm making sense of it that way.</p> <p>I still feel the same person I was.</p>	<p>8:211/2</p> <p>8:232; 236/7</p> <p>6:171/2</p>
Super-ordinate theme 3: <i>A dual bereavement</i>	<ul style="list-style-type: none"> - Facing disability - Physical loss adds to emotional loss 	<p>I'm grieving the loss of my ability to do certain things. Can't allow the grief I feel for both these things to keep going ... will make me less well emotionally and physically.</p> <p>So it's combined .. the loss of my mother adds to it ... Catch 22; .. affects my work.</p> <p>Can't <i>give</i> what I need and want to give.</p>	<p>12:344</p> <p>12:348-351</p> <p>12:345; 352</p> <p>13:365</p>
Super-ordinate theme 4: <i>Focusing on the relational: impact on practice</i>	<ul style="list-style-type: none"> - Personal experience enhances empathic understanding. - Facilitative and ethical self-disclosure - Role of supervision 	<p>I can empathise with them because I have experienced what they're feeling. There's this unseen energy..</p> <p>I can give them just that little piece to show them I understand and care about them. Would never impose my own feelings on a client ...</p> <p>I've felt comfortable talking about how it's related to my practice as well as speak to her on a personal level.</p>	<p>10:298-300</p> <p>11:322</p> <p>10/11:304/5</p> <p>10:294</p> <p>13:387-89</p>

	Cluster themes	In vivo quote	Page/line(s)
Super-ordinate theme 1: <i>The children as “chief mourners”</i>	<ul style="list-style-type: none"> -Relief from fear of abuse -Denial -Isolation -Emotional numbness -Staying in control/coping 	<p>He can't hurt me, he can't hurt the kids Burying the children's father; they were chief mourners No-one contacted me and no-one phoned me... It was very <i>heady</i>; it was very <i>coping</i></p>	<p>11:352 17:553-555 14: 459-460 33: 1042-1046</p>
Super-ordinate theme 2: <i>‘Left with a stigma’: impact on self and social identity</i>	<ul style="list-style-type: none"> -Stigmatisation/social exclusion -Perceptions of self -Challenges to beliefs 	<p>Not fitting in'; 'left with stigma It <i>didn't</i> fit with who I was .. God's got it all wrong ..</p>	<p>32:1019 22:690 22:713</p>
Super-ordinate theme 3: <i>“It’s <u>so</u> moulded who I am”: changes and personal growth</i>	<ul style="list-style-type: none"> -Being heard and accepted -Working through the grief -Integration of cognitive and affective -Growth 	<p>Accept me .. for who I was ... very, very, strange.. But it's a continual process . A heady place and .. seeped down to a more feeling place It feels like a maturing; I've changed so much ..</p>	<p>30:943-950 32:1019 54:1684-90 53:1675</p>
Super-ordinate theme 4: <i>The interface of the personal and professional</i>	<ul style="list-style-type: none"> -Triggers and challenges in training and client work -The role of supervision 	<p>First adult client ..drug addict'; '.. in front of me – who's <i>alive</i>.. And with that particular supervisor .. <i>fab</i> relationship And so we explored it a lot ..'</p>	<p>39:1224-1231 41:1288 42:1305-15 47:1466-69</p>
Super-ordinate theme 5: <i>From head to heart: personal experience enhances therapeutic practice</i>	<ul style="list-style-type: none"> -Connection and communication -Appropriate self-disclosure -Bringing the whole self to the therapeutic relationship 	<p>Really congruent..; was able to stay with her Seemed totally appropriate and crucial Not hide bits of you; because it's all there within me Offer a lot more of <i>that</i> part of me and <i>connect</i> with that part which in our relationship is how it works</p>	<p>44:1391-94 49:1523 4:101; 4:106 46:1453</p>

	Cluster themes	In vivo quote	Page/line(s)
Super-ordinate theme 1: <i>'Catapulted' to an alien realm</i>	<ul style="list-style-type: none"> - Powerlessness - Not being heard - Disconnection - Suppression of feelings 	Dropping this bombshell My wishes were squashed; devastating consequences Absolutely stunned; trying to be normal; suppressed my feelings; everything had changed	9:287 10:303/4; 1:22; 11:353 10:313-326
Super-ordinate theme 2: <i>'Beyond words': violation of the assumptive world</i>	<ul style="list-style-type: none"> - Violation – of child and of herself - Incomprehension - Injustice - Loss of trust in 'societal norms' 	Beyond words Completely in bits Felt like a specimen Huge distrust of NHS ..	13:424/5 13:427 13:419-424 20:662
Super-ordinate theme 3: <i>'The gift that comes out of the wreckage of pain': personal and spiritual growth transcends loss</i>	<ul style="list-style-type: none"> - From disintegration to re-integration - Spiritual growth - Making sense and finding meaning - Continuing bond with daughter 	Let the intensity of the anger go There are spiritual lessons we can learn ... I've survived; come through it; my poem... Re-engaged in a world that <i>still</i> has my little girl ..	20:667 21:696-704 16:515-529; 17:556-572 32:11076-79
Super-ordinate theme 4: <i>The interface of the personal and professional</i>	<ul style="list-style-type: none"> - From disconnection to reconnection - The value of personal therapy - Role of supervision - Integration of personal and professional development 	<i>Huge</i> connection Facing 'what is' and working through the pain; being comfortable enough .. Supervision was so validating 'Touchstones'; I can go there now; Open and ready; can re-integrate new learnings	22:718 20:669-672 28-30:936-983 31/32:1028-48 34:1130-1140
Super-ordinate theme 5: <i>Connectedness: personal experience enhances therapeutic practice'</i>	<ul style="list-style-type: none"> - Connectedness and meaningfulness - Appropriate, facilitative and ethical self-disclosure - Enhancement of therapeutic relationship 	Personal understanding of emotional pain; makes us both human So they know I really get it I can engage more effectively; come in as me; a soul-to-soul connection	25:822-835; 25:820-838 24:798-808 34:1121-24; 22:739

	Cluster themes	In vivo quote	Page/line(s)
Super-ordinate theme 1: <i>'Massive sense of compassion' ... Affective impact of bereavement</i>	<ul style="list-style-type: none"> - Peace - Liberation from fears - The death is frozen - Exhaustion 	<p>It seemed so <i>natural</i>. Real <i>peace</i>. Shown the worst it could get ..Liberated from a lot of fears. <i>That's</i> remained frozen. Not changed <i>at all</i>. Biggest thing .. absolute on-my-knees exhaustion.</p>	<p>9:258; 9:231 8:223</p> <p>6:163 5:118-20</p>
Super-ordinate theme 2: <i>'Excluded from cosy family life': Impact on self and social identity</i>	<ul style="list-style-type: none"> - Challenges to existing ideas and beliefs - Exclusion from peer group - Challenge to social identity - Lack of support 	<p>But things happened .. very odd. Had to let in more of a spiritual side ... not really me. My friends suddenly fell away. The minute I didn't fit that formula .. Felt <i>really</i> let down and unsupported.</p>	<p>10:288-90; 11:316;12:321-2 5:131;10:263 5:140</p>
Super-ordinate theme 3: <i>'I'm an entirely, entirely different person inside and out' (7:186/7): Change, growth and self-reflection</i>	<ul style="list-style-type: none"> - Personal growth - Positive changes in perspective and worldview - Rebuilding a new sense of identity - The paradoxical nature of change - Being 'witnessed' 	<p>Have all sorts of strengths . Released from pettiness</p> <p>It was an event ... but not an identity</p> <p>Have moved on but the death is an event that froze in time ...got to accept that it doesn't make sense. Life is less fragmented ...</p>	<p>7:191; 197 8:212</p> <p>18:507; 19:525</p> <p>20:553-559 23:648-654</p>
Super-ordinate theme 4: <i>The questioning professional self:</i>	<ul style="list-style-type: none"> - Reflecting on impact of bereavement on practice - Ethical dilemmas - The validating role of supervision - Reflecting on self-disclosure 	<p>Not scared .. I know how unique it all is.</p> <p>Wondering if I was being as effective as I could be It was just a real acceptance .. very supportive Has not come up that I've ever felt it's been in the service of the client ..</p>	<p>14:394/5</p> <p>22:626 31:871;884-887 20:571</p>
Super-ordinate theme 5: <i>'The relationship is what counts': impact on therapeutic practice</i>	<ul style="list-style-type: none"> - Being a 'witness' - Being genuine - Connection - Empathising and attuning 	<p>I can see how that heals .. I've got to be genuine Walking the same path; an expansion of my world I can tune into that - I was there</p>	<p>25:698 16:460 3:65; 70 26:728</p>

APPENDIX 30 Table 17

Table of master themes for the group

	Goldie	Harper	Jessica	Sophie
Master Theme 1: <i>Bereavement as a unique experience</i>				
<ul style="list-style-type: none"> Affective impact of bereavement and the evolving process of grieving 	I was starting to mourn my mother for two, three years ago. Felt I didn't get to really say goodbye.. there are always 'what-ifs' .. I'm still grieving. I miss her – so much.	He can't hurt me, he can't hurt the kids. <i>Nothing</i> was going on emotionally. It's an on-going process. My relationship with my husband and with his death changes over time.	Not heard. Completely catapulted to a different realm. Absolutely stunned. Powerless. Re-welcomed her into my heart .. carrying on <i>with</i> her..	No memory at all. Liberated from fears. On-my-knees exhaustion... Everything had changed .. but death still frozen.
<ul style="list-style-type: none"> Impact on self, social identity, beliefs, and world view 	I'm still me. Okay, I'm an orphan now which gives me another <i>label</i> . It makes me more acutely aware of my own mortality .. The world is changing very very quickly .. that feels sad and scary ..	Left with stigma and it was not fitting with my concept of who I am .. Isolated. Everyone was in fluffy, pink marriages. I'd married for life. Loss of innocence of faith .. It's a more useful faith.	Violation - of my daughter's body and <i>my</i> world .. beyond words. <i>Huge</i> distrust of NHS. Public interest in my private torment ..	Flooded with compassion and gratitude.. My friends just fell away .. The full impact of society's expectations came crashing upon me . I was excluded ..I didn't expect that..
Master Theme 2: <i>Re-learning the world</i>				
<ul style="list-style-type: none"> Personal growth and the re-construction of self 	I still feel the same person I was.	Freed from the tightness and being chained to the bereavement as a negative experience.. I've changed so much .. like lots of the changes.	I've survived .. I've come through it .. From feeling <i>no</i> connection to now feeling a <i>huge</i> connection. Re-engaged in a world that <i>still</i> has my little girl.	I'm an <i>entirely</i> different person inside and out. .. <i>Whole</i> feeling inside is so different .. found a <i>great</i> strength ..
<ul style="list-style-type: none"> Being heard and 'witnessed' 	Felt this would help me too ... bring about some type of <i>small</i> catharsis .. that it's a legitimate way of feeling ..	Mind-blowing .. really really blew me away that these people would accept me for who I was.	A <i>huge</i> contrast .. between <i>not</i> being heard and <i>being</i> heard. Working through to a more comfortable place.	It's had an immediate effect; life is less fragmented; more of a thread to it; knitted together..
Master Theme 3: <i>Personal & Professional</i>				

<i>Synergies</i>				
<ul style="list-style-type: none"> Integration of personal and professional reflection and development 	Tend to work from an intuitive level .. can feel what they're feeling .. I allow myself to take it in without harming myself ..	Self-knowledge and self-awareness .. it's what keeps my practice safe. From a heady place and ... seeped down to a more feeling place.	Existing in the 'fertile void'. Facing what is and working through the pain.. my experience as a client .. enhances my ability .. Can integrate new learnings.	Don't see myself as a person who's lost everything .. couldn't sit there ethically as I <i>do</i> believe in change .. and carrying on growing all through life ..
<ul style="list-style-type: none"> The validating role of supervision 	I've felt comfortable talking about how it's related to my practice ..	And with that particular supervisor .. <i>fab</i> relationship .. we've spoken a lot about .. the bereavement ..	Supervision was so validating .. Helped me engage more effectively with these [personal] issues.	It was just a real acceptance .. very supportive. And non-judgemental ..
Master Theme 4: <i>Impact on therapeutic practice</i>				
<ul style="list-style-type: none"> Personal experience enhances empathic understanding and connectedness 	I can empathise with them because I <i>have</i> experienced - am experiencing what they're feeling .. an unseen energy that can go between us..	I am who I am <i>because</i> of what I've been through .. You can only offer them the amount to which you've been prepared to go there yourself.	A personal understanding and insight of emotional pain .. makes us both human .. a soul-to-soul connection. I bring all of me into the room.	There's a neutrality around bereavement; an easiness with it. I'm not scared of it. I know how <i>unique</i> it all is. Everything that I am and everything that I bring ..
<ul style="list-style-type: none"> The issue of self-disclosure 	I can give them just that little piece to show I understand and <i>care</i> about them.	Holding it back.. Felt I was being untruthful. In that relationship it's been <i>crucial</i> .	So they know I've experienced and really understand the personal impact of such a loss..	I wouldn't assume it would be worth telling them .. Would be of the moment .. whatever was in the room.

APPENDIX 31

List of resources for bereavement support (for participants)

(NB Additional sources of support were included related to the geographical location of the participant, but are not cited here in order to preserve anonymity).

United Kingdom

BACP – www.bacp.co.uk

Bereavement Trust

General Helpline: Freephone 0800 435455 (eves. 6-10pm)

www.bereavementuk.co.uk

Childhood Bereavement Network UK

www.childhoodbereavementnetwork.org.uk

Cruse - www.crusebereavementcare.org.uk

Help the Hospices- www.hospiceinformation.info

Lesbian and Gay Bereavement Project

Counselling Dept.,

Lighthouse West London,

111-117, Lancaster Road,

London.

W11 1QT (Tel. 0207 403 5969)

www.macmillan.org.uk/HowWeCanHelp/bereavement

MIND - www.mind.org.uk

National Association of Widows

3rd Floor,

48, Queens Road,

Coventry.

CV1 3EH (tel. 024 7663 4848)

www.nawidows.org.uk

www.nhs.uk/livewell/bereavement

The Rainbow Centre

27, Lilymead Ave.,

Bristol. B54 2BY (Tel. 0117 985 43354)

www.rainbowcentre.org

www.samaritans.org.uk

The WAY Foundation

Suite 35,

St. Loyes House,

20, Loyes Street,

Bedford.

MK40 1ZL (Tel. 0 300 012 4929)

www.wayfoundation.org.uk

Winston's Wish

Clara Burgess Centre,

Bayshill Road,

Cheltenham,

Glos.

GL50 3AW (Tel. 01242 515157)

www.winstonswish.org.uk